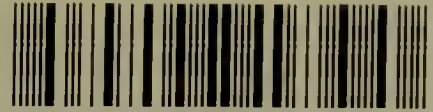


**SCHEME FOR
DEALING WITH
TUBERCULOUS
PERSONS . . .**

BARTY KING.

LSHTM



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10 APR. 1929

SCHEME
FOR
Dealing with Tuberculous Persons
IN THE
County of London :

its Application to other Cities, with some Observations on the National
Organization of the Campaign against Tuberculosis

BY

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TO

PROFESSOR SIR WILLIAM OSLER, Bt., M.D., F.R.S.,

AS A TOKEN OF ADMIRATION AND RESPECT FOR HIM AS
A PHYSICIAN AND FRIEND.

FOREWORD.

THE problem in tuberculosis is as much social as medical. In fifty years to have cut in half the death rate from the disease is a triumph (one of the greatest that preventive medicine has to show) due to a combination of factors—better housing, better food, better habits, better treatment. We know the enemy as never before, and we realize his strength—50,000 fatalities in 1914, and half a million wounded! A strong public opinion is in course of formation, without which the war cannot be carried on in an active, aggressive manner.

On paper the problem looks simple—

To put all in healthy environments with good housing and proper food, which are the essential preliminaries to healthy habits.

To recognize the disease early and to put the patients in the best possible circumstances to promote cure.

And to guard the community against dangers associated with advanced incurable cases.

The first is a basic economic question; rehousing will take at least a couple of generations. An abundant supply of good food means better wages, and a stricter protection against external contamination.

The second is met by efficient home treatment and by the hospitals, dispensaries and sanatoria.

The third by the closer supervision of dangerous cases and better provision for their segregation.

This paper simplicity vanishes with an attempt to draft a comprehensive scheme for the whole country or for a city, yet in organization lies the secret of success in the campaign. Dr. Barty King has proposed a scheme for dealing with tuberculosis in the County of London. It looks complicated, as does any great piece of machinery, but carefully constructed, managed by good engineers, and oiled by mutual good feeling, it should run smoothly and efficiently. I commend it heartily to the consideration of the public and my professional brethren.

WILLIAM OSLER.

PREFACE.

THE Scheme* which I have worked out, to deal in a comprehensive manner with Tuberculosis in the County of London, has taken about two years to complete, and is based, not only on the results of intimate practical observations made in connection with this work in London, but on an extensive practical experience gained in Tuberculosis work in this country in a general hospital, hospital for diseases of the chest, sanatorium for consumption in adults, sanatorium for consumption in children, Tuberculosis Dispensary, and in private practice, as well as on observations made in connection with similar work in Germany and in France.

Anyone who has endeavoured to solve the problem of dealing with Tuberculous Persons in London, will appreciate the enormous difficulties, social and economic, to be encountered and overcome in drawing up such a Scheme as this, but in so far as these are surmounted will its success be assured.

In reviewing this Scheme, it should be criticized on its merits alone, as an honest attempt to deal with this great problem, in a practical and comprehensive manner, regarded from the point of view of the various interests concerned. An endeavour has been made to utilize each available unit at its actual value. It is hoped that at least the groundwork of this Scheme may serve as a basis for profitable criticism and a constructive policy. If it serves such a purpose, the time spent on this laborious task by the author will not altogether have proved in vain.

Since this Scheme was completed, a Scheme for Dealing with Tuberculosis in the County of London has been passed by the London County Council. This fact will be welcomed by all who are interested in the solution of this difficult problem. A few criticisms of some of the principles it embodies will be found later (see p. 49).

The following comprise the essential features of my Scheme :—

(1) The recognition of the fact (*a*) that, both on medical and economic grounds, the Prevention of Consumption is better than its Cure, and (*b*) that one case of Pulmonary Tuberculosis overlooked may mean sickness, disablement, loss of employment and death to many.

* The publication of this book, which was completed in May last, was purposely delayed for certain specific reasons, municipal and otherwise, and has been further delayed owing to the War.

(2) The recognition of the vital importance of an intimate relation and co-operation between the Public Health Authority (through the Medical Officer of Health) and the various units of the Scheme, and more especially the Tuberculosis Dispensary, and that the Tuberculosis Officer shall be an official of the Public Health Authority of the borough, *re* public health, and yet shall be clinically independent of that authority.

(3) The core of the Scheme lies in the fact that provision has been made for the greatest possible number of centres for the examination of Tuberculous Persons, and in that lies the most potent factor in the detection of Tuberculosis, when combined with skill in diagnosis. Such a provision ensures also the best possible chance of examination of "Contacts" and of the detection of Tuberculosis in them.

(4) The Scheme provides for the utilization of all the best possible available institutions and more especially of the voluntary hospitals, and for the establishment of a Tuberculosis Dispensary inside a general or chest hospital, which shall become the parent Tuberculosis Dispensary of that district, and to which shall be affiliated a certain number of Tributary Tuberculosis Dispensaries. Such a provision makes for the utility—at a minimum cost—of the various special departments of the hospital, and of those skilled in the diagnosis and treatment of disease, and also safeguards the clinical material, so essential both to students of medicine, in whose hands the future health of the nation will rest, and to those medical practitioners who desire to keep themselves abreast of advances in diseases of the chest. Moreover, the utilization of our voluntary institutions not only ensures that the highest medical skill shall be obtained, but also that the Scheme shall be worked on a sound economic basis, at a minimum cost.

(5) Provision has also been made, in the case where there is no general or chest hospital with a Tuberculosis Dispensary, but a general hospital without a Tuberculosis Dispensary, for the latter to make arrangements for the provision of Treatment and Observation Beds both for insured and uninsured, which hospital shall be in the nature of an Associated Hospital, in relationship to the Associated Tuberculosis Dispensary (unattached) of that district.

Further, in the case where there is no general or chest hospital in a borough or neighbourhood, the authorities concerned, i.e., the London Insurance Committee and London County Council, or preferably, the Borough Councils themselves, with the approval of the London County Council, shall make provision for the establishment of Observation Beds in the borough, and—in cases where the diagnosis is doubtful—the Tuberculosis Officer of the Tuberculosis Dispensary shall deal directly

with the Medical Referee at the Central Bureau for sending cases into the Observation Wards, or for obtaining the Medical Referee's opinion without reference to these latter.

(6) The Scheme enacts that the Tuberculosis Dispensaries shall act as the "pivots" for the diagnosis, and, in certain special cases, for the treatment of Tuberculosis, and for the transference of Tuberculous Cases from one district to another.

(7) Provision has been made for the "Contacts" to be examined and re-examined, when possible, at the Tuberculosis Dispensary, by the Tuberculosis Officer, unless otherwise arranged for.

(8) Provision has been made for the insured and uninsured to be dealt with in one comprehensive Scheme, which shall make for greater medical efficiency and (financial) economy, and obviate the disadvantages associated with any system of divided authority. This is supported by the fact that—for various reasons—many insured persons, who have been treated as such, will, through inability to pay their contributions towards the National Health Insurance, come under the category of uninsured, and will therefore have to be dealt with later on by the Borough Councils.

(9) The provision of a Central Bureau, with Medical Referees, constituting a central court of appeal, safeguards the proper classification of cases recommended for Institutional Treatment, and is essential to any such Scheme, both on medical and economic grounds. Arrangements are also made by the Central Bureau for the filling of beds under the control of the London Insurance Committee and London County Council (or Borough Councils).

(10) In view of the vital importance of the segregation of certain advanced cases of Pulmonary Tuberculosis, provision should be made for their immediate accommodation, and there is no doubt that this can best be carried out by the utilization of the available beds in existing hospitals, or by the building of additional wings on to these hospitals. The segregation of Poor Law cases, when possible, should be provided for by the Metropolitan Asylums Board, in the Tuberculous Wards of the Poor Law infirmary hospitals. Failing such provisions, accommodation should be arranged for by the adaptation of any available institutions or by the building of new ones. In every case, such accommodation should be within the borough concerned, so that patients may not feel themselves ostracised from their families. Further, the provision of a suitable name for any such segregation institution should receive the serious consideration of the authorities concerned, that the patients may not in any way feel themselves branded with the stigma of their disease.

(11) The Scheme provides for the intimate help and co-operation of the voluntary agencies, which are essential to the welfare both of insured and uninsured.

(12) A practical endeavour has been made to eliminate hospital abuse, and to harmonize and safeguard the interests of the various units involved.

I have to record my indebtedness to my friends, the late Professor Nietner, Secretary of the Central Committee of the German Anti-Tuberculosis Association, to Professor Kaiserling, of Berlin, to Dr Rist, Physician to the Saënnec Hospital, Paris, and to Dr. H. B. Gibbins, D.P.H., late Tuberculosis Officer of the Department for the Prevention of Consumption at the Royal Hospital for Diseases of the Chest, for many valuable suggestions which have emanated from discussions in connection with this work, and also to my secretary, Miss E. J. Kell, for invaluable help in the compilation of the text, and for the execution of the illustrations.

May, 1914.

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Scheme for Dealing with Tuberculous Persons in the County of London.

AGENCIES DEALING WITH TUBERCULOSIS.

- (1) Medical practitioner (panel and non-panel).
- (2) Poor Law medical officer.
- (3) Public Health Authority (including the Medical Officer of Health and his staff).
- (4) Hospital for diseases of the chest, with or without a Tuberculosis Dispensary.
- (5) General hospital, with or without a Tuberculosis Dispensary.
- (6) Infirmary hospital.
- (7) Tuberculosis Dispensary.
- (8) General dispensary.
- (9) Sanatorium.
- (10) Institution for the treatment of advanced cases.
- (11) Medical Referees at Central Bureau.
- (12) Voluntary agencies.
- (13) Metropolitan Asylums Board, and Board of Guardians.

INSTITUTIONS DEALING WITH TUBERCULOSIS.

- (I) GENERAL HOSPITAL (FOR ADULTS OR CHILDREN) OR CHEST HOSPITAL, WITH A TUBERCULOSIS DEPARTMENT.

Department.

Staff.

- (a) Tuberculosis Department.

For diagnosis and treat-	{	Tuberculosis Consulting Physician.
ment.		„ Officer.
		„ Nurse.

The Staff of the Tuberculosis Dispensary shall consist of one or two Tuberculosis Consulting Physicians—preferably two—a Tuberculosis Officer, and one or more Tuberculosis Nurses. For duties, see pp. 41 and 42.

Scheme for Dealing with Tuberculous

(b) Out-patient department.

Insured ...	For diagnosis only	} Assistant physicians.
Uninsured ...	For diagnosis, and treatment permitted if unable to pay	

(c) Special departments.

(1) X-ray	} For diagnosis and treatment of insured and uninsured	} Physicians and surgeons.
(2) Bacteriological laboratory		
(3) Surgical		
(4) Throat		
(5) Eye		
(6) Cardiological		

(d) In-patient department.

Insured ...	{ London Insurance Committee beds	(1) For treatment (Ordinary, Special, and Emergency)	} Physicians and resident medical officer.
		(2) For observation	
Uninsured	{ London County Council (or Borough Council) beds	(1) For treatment (Ordinary, Special, and Emergency)	
		(2) For observation	
	Voluntary beds...	For treatment	

(e) Wings, or wards, for the treatment of advanced cases.

Insured ...	London Insurance Committee beds	} Physicians.
Uninsured...	London County Council (or Borough Council) beds	

(II) GENERAL OR CHEST HOSPITAL, WITHOUT A TUBERCULOSIS DISPENSARY.

(a) Out-patient department. See (I) (b).

(b) Special departments. See (I) (c).

(c) In-patient department. See (I) (d).

(d) Wings, or wards, for the treatment of advanced cases. See I (e).

(III) TUBERCULOSIS DISPENSARY OUTSIDE A HOSPITAL.

Staff.

For diagnosis and treatment (Special).	In-	{ Tuberculosis Officer.
sured and uninsured		

(IV) GENERAL DISPENSARY WITH A TUBERCULOSIS DISPENSARY.

For diagnosis and treatment (Special).	In-	{	Tuberculosis Consult-
insured and uninsured			ing Physician.
			Tuberculosis Officer.
			„ Nurse.

(V) GENERAL DISPENSARY WITHOUT A TUBERCULOSIS DISPENSARY.

Physicians and resident medical officer.

(VI) POOR LAW INFIRMARY HOSPITAL. (TUBERCULOSIS WARDS.)

For treatment of Poor Law Tuberculous	{	Medical Superintendent.
Persons. Uninsured		

(VII) INSTITUTIONS FOR THE TREATMENT OF ADVANCED CASES.

(Unattached.) For insured and uninsured. Physicians.

(VIII) SANATORIUM.

Insured and uninsured, for treatment of	{	Medical Superintendent
early cases of pulmonary tuberculosis		
		and Assistants.

PROVISION OF BEDS.

HOSPITAL BEDS FOR

(a) Treatment. (b) Segregation. (c) Observation.

INSURED PERSONS.

The London Insurance Committee should acquire beds in hospitals (which have been approved by the Local Government Board) for dealing with cases under the above classification, and a list of beds in such institutions should be sent to the Central Bureau, so that the Medical Referee may refer to these beds such cases as he may recommend.

UNINSURED PERSONS.

(a) The Borough Councils, through the London County Council, should acquire beds in hospitals (which have been approved by the Local Government Board) for dealing with cases (uninsured) under the above classification, and a list of beds in such institutions should be sent to the Central Bureau, so that the Medical Referee may refer to these beds such cases as he may recommend.

(b) The Board of Guardians, through the Metropolitan Asylums Board, should acquire beds in the Poor Law infirmary hospital for dealing with Poor Law cases under the above classification, which have been recommended for such treatment by the Medical Referee at the Central Bureau.

CENTRAL BUREAU.**MEDICAL DEPARTMENT.****CLERICAL DEPARTMENT.****CENTRAL BUREAU.**

The Central Bureau shall consist of :—

- | | | |
|-------------------------|-----|--|
| (A) Medical department | ... | { Medical Referees (one or more).
Tuberculosis Nurse. |
| (B) Clerical department | ... | { Secretary.
Clerks. |

(A) MEDICAL DEPARTMENT.

The Medical Referees shall receive from the clerical department the Medical Records of all cases which have been referred to the Central Bureau for decision as to treatment, and decide as to :—

- (a) Sanatorium Treatment.
- (b) Hospital Treatment.
- (c) Tuberculosis Dispensary or Domiciliary Treatment.
- (d) Treatment of advanced cases (Segregational).

The decision shall be based on :—

- (a) Physical conditions of the patient.
- (b) Home conditions and general environment of the patient.
- (c) Likelihood of the patient's regaining his or her working power.

*Composition of the Medical Staff.**

Scheme (1).—Two physicians shall sit three days a week each, from 2 to 5 o'clock. To be appointed for three years with the option of re-election for six.

Or :—

Scheme (2).—Three physicians shall sit for two days a week each, from 2 to 5 o'clock. To be appointed for three years with the option of re-election for six.

Or :—

Scheme (3).—Three seniors and three juniors shall sit for two days a week each, from 2.30 to 4.30. The seniors to be appointed for three years, to retire at the end of that period, and the juniors to be appointed seniors in their stead.

There shall be one Tuberculosis Nurse.

(B) CLERICAL DEPARTMENT.

The Clerical Staff is to refer to the Medical Referee for his decision, together with the Medical Records, those cases recommended for

* As the scheme evolves, and the Local Tuberculosis Medical Officers find their true sphere of work, the Central Bureau Medical Staff could be reduced.

Institutional Treatment from : (a) the Tuberculosis Officer of the Tuberculosis Dispensary inside a general or chest hospital ; (b) the Tuberculosis Officer of the Tuberculosis Dispensary outside a hospital.

Arrangements for dealing with a case recommended for Institutional Treatment are detailed in Example Case, p. 47.

MEDICAL RECORDS.

The Medical Records of the cases which are sent to the Medical Referee for final decision are to be returned to the institutions concerned, immediately afterwards, together with reports of the Medical Referee's decision, to the Tuberculosis Dispensaries concerned.

(1) If Sanatorium Treatment is recommended, and decided on by the Medical Referee, then the Medical Record is sent on to the sanatorium, together with a letter to the patient (wherever he is being treated at the time). If the patient is not found suitable for Sanatorium Treatment, the Medical Record is returned to the Tuberculosis Dispensary together with a report as to the decision.

(2) If Hospital Treatment is recommended, and decided on by the Medical Referee, a letter shall be sent to the patient, informing him as to the arrangements for treatment. Letters are sent to the Tuberculosis Dispensary and panel doctor or general practitioner informing them of the decision, and the Medical Record is sent to the hospital where the treatment is to be carried out.

(3) If the case is referred back to the Tuberculosis Dispensary for Domiciliary Treatment by the panel doctor or general practitioner, or for other form of treatment, then a letter is sent to each of these, informing them of the Medical Referee's decision, and the Medical Record is returned to the Tuberculosis Dispensary. The Tuberculosis Officer will make arrangements for the case to be dealt with accordingly.

(4) If the case is recommended for London Insurance Committee or London County Council (or Borough Council) segregation beds in the wards of the general or special hospitals, or in institutions for the treatment of advanced cases, letters are sent to the panel doctor or Tuberculosis Officer of the Tuberculosis Dispensary informing them of the decision, and the case, together with the Medical Record, is sent to the institution, where the treatment is to be carried out.

Beds available for treatment and segregation of the insured (at the disposal of the London Insurance Committee) and of the uninsured (at the disposal of the London County Council (or Borough Councils)).

(1) (a) Beds for Institutional Treatment (ordinary or special) in a sanatorium or hospital.

Arrangements for the filling of these beds are to be made directly through the Central Bureau.

(b) Beds for the Treatment of Advanced Cases in a General or Chest Hospital, or Special Institution. (Segregational).

Arrangements for the filling of these beds are to be made directly through the Central Bureau.

(c) Beds for the Treatment of Advanced Cases in the workhouse infirmary hospital.

Arrangements for the filling of these beds are to be made directly through the Metropolitan Asylums Board or Board of Guardians.

(d) Beds for treatment in a general or chest hospital without a Tuberculosis Dispensary.

Arrangements for the filling of these beds with cases referred from an Associated Tuberculosis Dispensary must be made by the Tuberculosis Officer of that Tuberculosis Dispensary directly through the Central Bureau.

(2) Beds for Observation.

Arrangements for the filling of these beds can be made by the Tuberculosis Officer, on the advice of the Tuberculosis Consulting Physician, but notice must be immediately made to the Central Bureau.

The Tuberculosis Officer of an Associated Tuberculosis Dispensary is not authorized to fill these beds, except by first referring the Medical Records of the cases to the Medical Referee at the Central Bureau.

COMMITTEE OF MANAGEMENT OF THE CENTRAL BUREAU.

Suggested formation :—

Representatives of the uninsured (London County Council) ...	=	6
„ „ insured (London Insurance Committee) —		3
		—
Total		9

The Medical Officer of Health for the County of London shall be ex-officio a member of this Committee.

(1) The Committee of Management shall have the control of the whole working of the Central Bureau.

(2) The Medical Referees shall be appointed by the London County Council, on the recommendation of the Committee of Management.

(3) The Committee of Management shall have the power of requesting the Medical Referees to attend any meetings, when their advice on medical matters is desired.

In appointing Medical Referees, the following considerations should be taken into account :—

As the Tuberculosis Dispensaries are to deal with *all* cases of Tuberculosis, the question as to having an expert surgeon as a Referee must be considered.

In view of the great difficulty of the diagnosis of Pulmonary Tuberculosis in children, the importance of the appointment of men who have had special experience in dealing with these cases must not be overlooked.

INSURED PERSONS.

CONTENTS.

- (A) Persons presenting themselves to the panel doctor.
- (B) Persons presenting themselves for examination and treatment at a general or chest hospital, with a Tuberculosis Dispensary, which hospital may act as an Affiliated Hospital centre.
 - (1) *Out-patient department.*
 - (a) Cases referred by the panel doctor for diagnosis.
 - (b) Cases coming up with a hospital out-patient letter or otherwise.
 - (2) *In-patient department.*
 - (a) Beds for treatment $\left\{ \begin{array}{l} \text{London Insurance Committee.} \\ \text{Voluntary.} \end{array} \right.$
 - (b) Beds for observation. London Insurance Committee.
 - (3) *Tuberculosis Dispensary* or Department for the Prevention of Consumption.
 - (a) Special and emergency cases sent by the panel doctor for treatment.
 - (b) Cases sent by the London Insurance Committee, through the Central Bureau, by decision of the Medical Referee.
 - (c) Cases sent for diagnosis by the panel doctor or Tuberculosis Officer of the Affiliated Tuberculosis Dispensary.
 - (d) Cases coming with or without Tuberculosis Dispensary admission cards, or from voluntary agencies, with Tuberculosis Dispensary admission cards.
 - (e) Cases referred, having been diagnosed as tuberculous from the Observation Wards.
 - (f) Cases discharged after Institutional Treatment.
 - (g) Transferred cases from other districts.
 - (h) Contact cases.
- (C) Persons presenting themselves at a Tuberculosis Dispensary outside a hospital.

(1) Cases sent by the London Insurance Committee, through the Central Bureau.

(2) Cases sent by the panel doctor for treatment.

(3) Cases sent by the panel doctor for diagnosis.

(4) Cases coming independently or from voluntary agencies, by Tuberculosis Dispensary admission cards.

(5) Cases discharged after Institutional Treatment.

(6) Cases transferred from other districts.

(7) Cases coming as "contacts."

(D) Persons presenting themselves at a Tuberculosis Dispensary inside a general dispensary (sub-divisions as in C).

(E) Persons presenting themselves at a hospital or other institution without a Tuberculosis Dispensary, or at an ordinary general dispensary.

(1) Out-patient department.

(2) In-patient department	{ Voluntary Beds. { London Insurance { Committee Beds { For Treatment. { „ Observation.

(F) Transferred insured Tuberculous Persons.

INSURED PERSONS.

A.—PERSONS PRESENTING THEMSELVES TO THE PANEL DOCTOR.

The case is examined, and if found tuberculous, is notified to the Medical Officer of Health of the patient's borough.

A short medical report is sent to the Tuberculosis Dispensary giving the result of the examination, and the form of treatment recommended.

On receipt of this report, and if Tuberculosis Dispensary treatment is recommended, the Tuberculosis Officer will arrange for it to be carried out, or, if in his opinion it is desirable for him to make further inquiries, he shall arrange for a consultation with the panel doctor.

If Domiciliary Treatment is recommended, the panel doctor will carry it out, but if Institutional Treatment (in a sanatorium, hospital or institution for advanced cases) is recommended, a consultation shall be arranged between the panel doctor and the Tuberculosis Officer at the Tuberculosis Dispensary.

In the case where the Tuberculosis Dispensary is a department of a general or special hospital, all cases referred to that Tuberculosis Dispensary by the panel doctor must be seen by the Tuberculosis Consulting Physician.

If the Tuberculosis Consulting Physician recommends Institutional Treatment, the case is referred by the Tuberculosis Officer to the Medical Referee for his final decision.

If the Tuberculosis Dispensary is outside a hospital, a consultation is held between the Tuberculosis Officer and panel doctor, and if Institutional Treatment is recommended, the case is referred, with the Medical Record, to the Medical Referee for his final judgment and decision.

The panel doctor may refer any case to the Tuberculosis Dispensary for consultation, with a view to an opinion in diagnosis, treatment, &c. (See B (3), Sections (a), (b) and (c), and C (2) and (3).)

In the case of any disagreement between the panel doctor and the Tuberculosis Officer, the case shall be referred to the Medical Referee.

If the panel doctor cannot be present at any Tuberculosis Dispensary consultation, then a report of the decision shall be sent to him by the Tuberculosis Officer.

The Medical Officer of Health instructs the Tuberculosis Officer of the Tuberculosis Dispensary to examine Contacts.

The Tuberculosis Nurse arranges for the examination and re-examination of the Contacts by the Tuberculosis Officer, where possible at the Tuberculosis Dispensary, and if, after examination, he finds one or more suffering from Tuberculosis, he classifies, notifies, and refers to the panel doctor, for Domiciliary Treatment (if this be recommended) those persons who are insured, while those who are uninsured are dealt with as in A (Uninsured), *i.e.*, referred to a general practitioner, if able to pay, and to the Tuberculosis Dispensary if unable to pay.

If Institutional Treatment is recommended by the Tuberculosis Officer, the procedure is as above (p. 8).

N.B.—Final decision as to treatment in :—

- (a) Sanatorium,
- (b) Hospital Wards for Advanced Cases,
- (c) Institutions for Advanced Cases, must be made by the Medical Referee at the Central Bureau.

B.—PERSONS PRESENTING THEMSELVES FOR EXAMINATION AND TREATMENT AT A GENERAL OR CHEST HOSPITAL WITH A TUBERCULOSIS DISPENSARY, WHICH HOSPITAL MAY ACT AS AN AFFILIATED HOSPITAL CENTRE.

(1) Out-patient department.

(a) *Cases referred by the panel doctor for diagnosis.*

Cases residing in the hospital area.—If found tuberculous, the case is notified to the Medical Officer of Health, who makes the usual arrangements for Contacts. (See A.)

The case is referred by the out-patient physician to the panel doctor, together with a short medical report, and is further dealt with as in A. (Pp. 8 and 9.)

If the case is doubtful, and requires further observation, it is referred to the panel doctor, together with a short medical report, and the panel doctor deals with it as in A.

If the case is found non-tuberculous, it is referred back to the panel doctor with a short medical report.

Cases not residing in the hospital area.—The procedure is the same as in the above cases, except that notification is made to the Medical Officer of Health of the patient's borough, and the patient, if he has no panel doctor, is referred to the Tuberculosis Dispensary of his area, to be dealt with. (See B (3) or C.)

(b) *Cases coming up with a hospital out-patient letter or otherwise.*

If a case comes up without a note from the panel doctor it must be examined and dealt with as in Section (a), i.e., referred to the panel doctor. Arrangements are made for Contacts.

All insured cases coming to the out-patient department must be examined, but not treated, except in cases of emergency.

(2) **In-patient department.**

(a) Beds for treatment { London Insurance Committee.
 { Voluntary.

(b) Beds for observation (London Insurance Committee).

The patient is examined by the Resident Medical Officer, and if found tuberculous, notified by the latter to the Medical Officer of Health of the hospital borough, and also to the Medical Officer of Health of the patient's borough, if this has not already been done.

Arrangements are made for Contacts.

(a) London Insurance Committee Beds.—Cases are sent in to these beds by the London Insurance Committee, through the Central Bureau from the Tuberculosis Dispensary. The Medical Officer of Health of the patient's borough makes the usual arrangements for Contacts, if this has not already been done. (See A.)

Voluntary beds.—Cases presenting themselves independently by hospital admission letter.

The case is examined by the Resident Medical Officer, and if tuberculous is notified to the Medical Officer of Health of the patient's borough (who makes the usual arrangements for Contacts), and the case itself is referred to the panel doctor to be dealt with.

(b) *Observation beds* (London Insurance Committee).—Cases are sent

in to these beds for diagnosis, from the Hospital Tuberculosis Dispensary. (See B (3), (c) and (e).)

If diagnosed as tuberculous, the case is referred to the Hospital Tuberculosis Dispensary for notification, classification, and arrangements for treatment, and examination of Contacts.

If diagnosed as non-tuberculous, the case is sent to the Hospital Tuberculosis Dispensary to be further dealt with.

Cases may also be sent to these beds from an Affiliated Tuberculosis Dispensary. (See B (3), (c) and (e).)

If diagnosed as tuberculous, the case is referred back to the Affiliated Tuberculosis Dispensary for notification, to be dealt with accordingly, and arrangements made for Contacts. (See A.)

If diagnosed as non-tuberculous, the case is referred back to the Affiliated Tuberculosis Dispensary.

N.B.—CASES SENT TO THE HOSPITAL WARDS FROM AFFILIATED
TUBERCULOSIS DISPENSARIES.

(a) *Beds (London Insurance Committee).*

(1) Cases for Ordinary Treatment.—Arrangements are made through the Central Bureau only.

(2) Cases for Special Treatment (surgical, throat, etc.).—Arrangements are made through the Central Bureau only.

(3) Cases for Emergency Treatment.—Arrangements are made by the Tuberculosis Officer of the Hospital Tuberculosis Dispensary. (See B (3), Section (a).)

(b) *Observation Beds (London Insurance Committee).* (See B (2) Section (b).)

N.B.—After discharge from London Insurance Committee beds, the patient is referred to the Hospital Tuberculosis Dispensary, and the Tuberculosis Officer, on the advice of the Tuberculosis Consulting Physician, may then refer any case to the Medical Referee for Institutional Treatment.

B.—(3) **Tuberculosis Dispensary, or Department for the Prevention
of Consumption.**

Cases may present themselves as follows :—

(a) Special and emergency cases, sent by the panel doctor for treatment.

(b) From the London Insurance Committee (for special treatment), through the Central Bureau, by decision of the Medical Referee.

(c) From the panel doctor, or affiliated Tuberculosis Dispensary, for diagnosis, treatment, or both.

(d) Independently, or from voluntary agencies, for diagnosis, treatment, or both.

(e) Referred from the Observation Wards of the in-patient department.

(f) On discharge after Institutional Treatment.

(g) As transferred cases from other districts.

(h) As Contacts, for examination and re-examination.

From whatever channel the case may come, the patient's "Case-Record-Notes" are taken by the Tuberculosis Nurse—unless this has been done already—*i.e.*, the name, address and circumstances of family, etc. The case is scheduled and classified. Immediately after the first visit of the patient, arrangements are made by the Tuberculosis Nurse for the examination of Contacts by the Tuberculosis Officer of the Tuberculosis Dispensary.

(a) and (b) SPECIAL AND EMERGENCY CASES SENT BY THE PANEL DOCTOR FOR TREATMENT, ALSO THOSE CASES SENT BY THE LONDON INSURANCE COMMITTEE, THROUGH THE CENTRAL BUREAU, BY DECISION OF THE MEDICAL REFEREE.

Certain exceptional cases which the panel doctor cannot reasonably be expected to treat are referred to the Tuberculosis Dispensary for treatment; also those cases which the panel doctor reasonably desires to be treated at the Tuberculosis Dispensary.

Under these circumstances, the case is first seen by the Tuberculosis Consulting Physician, and arrangements made by the Tuberculosis Officer for treatment at the Tuberculosis Dispensary.

These cases are notified, and arrangements made for Contacts, if not already made.

Cases are also referred from the Central Bureau through the Medical Referee, for Tuberculosis Dispensary treatment.

Arrangements are made for such treatment to be carried out by the Tuberculosis Officer at the Tuberculosis Dispensary.

Cases are also referred for *Special Treatment* :—

(1) From the hospital Tuberculosis Dispensary.

(2) From the panel doctor.

The Tuberculosis Officer must, on special form provided, note the form of treatment desired, and where it is to be carried out, and send this chart form, together with the Medical Record of the case, to the Medical Referee for his final decision, and, if granted, arrangements shall be made accordingly.

Emergency Cases (as Hæmoptysis, Pneumothorax, Acute Spread, etc.),
Referred (1) from the Hospital Tuberculosis Dispensary.
(2) from the Affiliated Tuberculosis Dispensary.
(3) from the panel doctor.

The Tuberculosis Officer shall have the power of sending such cases direct to the hospital beds, informing the Medical Referee immediately, and sending special form on to that authority.

(c) Cases sent for consultation as to diagnosis by the panel doctor, or general practitioner or Tuberculosis Officer of the Affiliated Tuberculosis Dispensary.

The case is examined by the Tuberculosis Consulting Physician.

Where possible, arrangements are made for the panel doctor or Tuberculosis Officer of an Affiliated Tuberculosis Dispensary to be present at the examination.

If the panel doctor or Tuberculosis Officer of the Affiliated Tuberculosis Dispensary is unable to be present, a medical report of the case shall be immediately sent to him *re* the diagnosis and classification of treatment.

If the case proves to be tuberculous it is notified to the Medical Officer of Health, who makes arrangements for Contacts. (See A.)

Arrangements are made for the treatment of the case by the panel doctor or Tuberculosis Officer of an Affiliated Tuberculosis Dispensary. (See A.)

If the case is non-tuberculous, it is referred back to the panel doctor or the Tuberculosis Officer of the Affiliated Tuberculosis Dispensary, with a short medical report.

If the case is doubtful it is sent to the Observation Wards for further observation. (See B 2, Section (b).)

The Tuberculosis Officer of the Tuberculosis Dispensary may, if he desires, refer a case for diagnosis to the Observation Wards, but only with the approval of the Tuberculosis Consulting Physician, and in all such cases the Central Bureau must be immediately informed.

(d) Cases coming with or without Tuberculosis Dispensary admission cards, or from Voluntary Agencies, with Tuberculosis Dispensary admission cards.

The case is examined by the Tuberculosis Officer, and, if found tuberculous, is notified to the Medical Officer of Health concerned, who makes arrangements for Contacts. (See A.)

The patient, whether tuberculous or not, is referred to the panel doctor with a medical report as to diagnosis, and—if tuberculous—classification of treatment.

The panel doctor of the patient's borough deals with the case as under A.

(c) Cases referred, having been diagnosed as tuberculous from the Observation Wards.

The case is notified by the Tuberculosis Officer to the Medical Officer of Health of the patient's area, who makes arrangements for Contacts.

The case is referred to the panel doctor to be dealt with. (See A.)

Cases sent up to Observation Wards from the Affiliated Tuberculosis Dispensaries.

Such cases are referred back through the Hospital Tuberculosis Dispensary, to their respective Affiliated Tuberculosis Dispensaries to be dealt with, and if tuberculous, notified to the Medical Officer of Health by the Tuberculosis Officers of the latter Tuberculosis Dispensaries, and arrangements made for "Contacts."

(f) Cases discharged after Institutional Treatment.

Such cases, after examination, and consideration of the Medical Records, are dealt with accordingly.

(g) Transferred Cases from other districts. (See Section F.)

(h) Cases coming as Contacts. (See Section A.)

N.B.—Opportunities shall be granted by the Tuberculosis Dispensary authorities for certain privileged persons to make use of the Medical Records at the Tuberculosis Dispensary for purposes of research in Tuberculosis.

C.—PERSONS PRESENTING THEMSELVES AT A TUBERCULOSIS DISPENSARY OUTSIDE A HOSPITAL.

Cases may present themselves as follows:—

(1) From the London Insurance Committee, through the Central Bureau, and on the advice of the Medical Referee.

(2) From the panel doctor for treatment.

(3) From the panel doctor for diagnosis.

(4) Independently, by Tuberculosis Dispensary Admission Cards.

(5) On discharge, after Institutional Treatment.

(6) As transferred cases from other districts.

(7) As "Contacts" for examination and re-examination.

From whatever channel the case may come, the patient's "Case-Record-Notes"—unless this has already been done—are taken by the Tuberculosis Nurse, *i.e.*, name, address, and circumstances of family, etc., and the case is scheduled and classified. Immediately after the first visit of the patient, arrangements are made by the Tuberculosis Nurse for the examination of Contacts by the Tuberculosis Officer of the Tuberculosis Dispensary.

(1) and (2) Cases sent by the London Insurance Committee, through

the Central Bureau, and on the advice of the Medical Referee; also cases sent by the panel doctor for treatment.

Procedure as under B (3), Section (a), with the exception that the case is examined only by the Tuberculosis Officer of the Tuberculosis Dispensary, and also that, if Institutional Treatment is recommended for those cases sent up by the panel doctor, the case is referred direct from the Tuberculosis Officer to the Medical Referee at the Central Bureau, unless there should arise a doubt as to the diagnosis, or a disagreement in the diagnosis between the Tuberculosis Officer and the panel doctor, when the case *may* be referred to the Tuberculosis Consulting Physician of an Affiliated Hospital, should there be one.

If there is no Affiliated Hospital, the case is referred direct to the Medical Referee for his decision.

In all cases, after examination, the Tuberculosis Officer may, if necessary, refer the case for diagnosis to the Observation Wards of the Affiliated Hospital. (See B (3), Section (e).)

If there is no Affiliated Hospital with a Tuberculosis Dispensary, but an Associated Hospital without a Tuberculosis Dispensary, the Tuberculosis Officer of the Associated Tuberculosis Dispensary may refer any case for diagnosis to the Observation Wards of the latter Hospital, after making arrangements with the Central Bureau for the admission of the case.

(3) Cases sent by the panel doctor of the Tuberculosis Dispensary area, for diagnosis.

The case is examined by the Tuberculosis Officer in consultation with the panel doctor, and :—

(a) If tuberculous, the case is notified, and arrangements made for Contacts by the Medical Officer of Health concerned. (See A.)

If the panel doctor is not present at the consultation, a medical report shall be immediately sent to him, and on receipt of such report, the panel doctor shall deal with the case as under A.

(b) If the case is found non-tuberculous, see B (3), Section (c).

(c) If the case is doubtful, or in the event of a disagreement between the Tuberculosis Officer and the panel doctor, the case may be referred to the Tuberculosis Dispensary of the Affiliated Hospital centre. (See B (3) Section (c).)

If there is no Affiliated Hospital with a Tuberculosis Dispensary, but an Associated Hospital without a Tuberculosis Dispensary, then arrangements must first be made with the Central Bureau for the admission of such cases to the Observation Wards.

If there is no Associated Hospital, the case is referred direct to the Medical Referee.

(4) Cases presenting themselves independently by Tuberculosis Dispensary admission cards.

The case is examined by the Tuberculosis Officer.

(a) If found tuberculous it is notified to the Medical Officer of Health concerned, who makes arrangements for Contacts. (See A.) The case itself is referred to the panel doctor with a short medical report.

(b) If the case is doubtful, it may be referred for diagnosis to the Tuberculosis Dispensary of the Affiliated Hospital centre (See B. (3), Section (c), or C, (1) and (2).)

(5) Cases discharged after Institutional Treatment.

Such cases, after examination, and consideration of the clinical notes, are dealt with accordingly.

(6) Cases transferred from other districts. (See Section F.)

(7) Cases coming as "Contacts." (See Section A.)

N.B.—In all cases, opportunities shall be granted by the Tuberculosis Dispensary authorities for certain privileged persons to make use of the Medical Records at the Tuberculosis Dispensary, for purposes of research in Tuberculosis.

D.—PERSONS PRESENTING THEMSELVES AT A TUBERCULOSIS DISPENSARY INSIDE A GENERAL DISPENSARY.

Cases may present themselves as follows :—

(1) From the London Insurance Committee, through the Central Bureau, and on the advice of the Medical Referee.

(2) From the panel doctor for treatment.

(3) From the panel doctor for diagnosis.

(4) Independently, by Tuberculosis Dispensary admission cards.

(5) On discharge, after Institutional Treatment.

(6) As transferred cases from other districts.

(7) As "Contacts" for examination and re-examination.

From whatever channel the case may come, the patient's "Case-Record-Notes"—unless this has already been done—are taken by the Tuberculosis Nurse, *i.e.*, name, address and circumstances of family, etc., and the case is scheduled and classified. Immediately after the first visit of the patient, arrangements are made by the Tuberculosis Nurse for the examination of contacts by the Tuberculosis Officer of the Tuberculosis Dispensary.

(1) and (2) Cases sent by the London Insurance Committee, through the Central Bureau, and on the advice of the Medical Referee, also cases sent by the panel doctor for treatment.

The case is first seen by the Tuberculosis Consulting Physician, and

arrangements are made by the Tuberculosis Officer for treatment at the Tuberculosis Dispensary.

These cases are notified, and arrangements made for Contacts—if this has not already been done.

If Institutional Treatment is recommended by the Tuberculosis Consulting Physician for those cases sent up by the panel doctor, they are referred direct to the Medical Referee at the Central Bureau.

After examination, the Tuberculosis Officer, on the advice of the Tuberculosis Consulting Physician, may, if necessary, refer the case for diagnosis to the Observation Wards of the Affiliated Hospital (see B (3), Sections (c) and (c)); but the Central Bureau must be informed.

If there is no Affiliated Hospital with a Tuberculosis Dispensary, but an Associated Hospital without a Tuberculosis Dispensary, the Tuberculosis Officer of the Associated Tuberculosis Dispensary, on the advice of the Tuberculosis Consulting Physician, may refer any case for diagnosis to the Observation Wards of the latter Hospital, after making arrangements with the Medical Referee of the Central Bureau for the admission of the case.

(3) Cases sent by the panel doctor of the Tuberculosis Dispensary area, for diagnosis.

The case is examined by the Tuberculosis Consulting Physician, in consultation with the panel doctor, and

(a) If tuberculous, the case is notified, and arrangements made for Contacts by the Medical Officer of Health concerned. (See A.)

If the panel doctor is not present at the consultation, a medical report shall be immediately sent to him, and on receipt of such report, the panel doctor shall deal with the case as under A.

(b) If the case is found non-tuberculous, it is referred back to the panel doctor with a short medical report.

(c) If the case is doubtful, the Tuberculosis Officer, on the advice of the Tuberculosis Consulting Physician, may refer it to the Observation Wards of the Affiliated Hospital, through the Tuberculosis Dispensary of that hospital.

For procedure when there is no Affiliated Hospital, but only an Associated Hospital (see D (1) and (2)).

(4) Cases presenting themselves independently, by Tuberculosis Dispensary admission cards.

The case is examined by the Tuberculosis Officer. If tuberculous, it is notified to the Medical Officer of Health concerned, who makes arrangements for Contacts.

The patient, whether tuberculous or not, is referred to the panel

doctor with a medical report as to diagnosis, and—if tuberculous—classification of treatment.

The panel doctor of the patient's borough deals with the case as under A.

(5) Cases presenting themselves on discharge after Institutional Treatment.

Such cases, after examination, and consideration of the Medical Records, are dealt with accordingly.

(6) Transferred cases from other districts. (See Section F.)

(7) Cases coming as "Contacts." (See Section A.)

N.B.—In all cases, opportunities shall be granted by the Tuberculosis Dispensary authorities for certain privileged persons to make use of the Medical Records at the Tuberculosis Dispensary for purposes of research in Tuberculosis.

E.—PERSONS PRESENTING THEMSELVES AT A HOSPITAL OR OTHER INSTITUTION WITHOUT A TUBERCULOSIS DISPENSARY, OR AT AN ORDINARY GENERAL DISPENSARY (NO IN-PATIENTS).

(1) **Out-patient department** (or ordinary general dispensary).

All cases are examined, and if found tuberculous, classified and notified to the Medical Officer of Health concerned, who makes arrangements for Contacts. (See A.)

The case, whether tuberculous or not, is referred to the panel doctor concerned to be dealt with, as under A.

(2) **In-patient department.** (Approved for treatment by the Local Government Board.)

(a) Voluntary beds.

Cases coming with in-patient letters. The case is examined by the Resident Medical Officer, and if found tuberculous, is notified to the Medical Officer of Health of the hospital borough, and also to the Medical Officer of Health of the patient's borough (should these not be identical). The Medical Officer of Health of the patient's borough makes the usual arrangements for Contacts. (See A.)

A case, whether tuberculous or not, is referred, together with a short medical report, to the panel doctor, to be dealt with as under A.

(b) Beds (London Insurance Committee.)

Cases sent in by the London Insurance Committee for ordinary or special treatment. (Through the Central Bureau.)

The patient is dealt with as under B (2), Section (a).

Emergency Cases.—The Tuberculosis Officer of the Associated Tuberculosis Dispensary has the power of sending cases direct to the Emergency Beds, but he must immediately notify the Medical Referee of the Central Bureau.

(c) Observation Beds (London Insurance Committee).

If no general or special hospital with Tuberculosis Dispensary is provided in the area, the Tuberculosis Officer can refer any doubtful cases for diagnosis to the Observation Wards of the Associated Hospital, but he must first make arrangements with the Central Bureau for the admission of such cases.

After observation and diagnosis, the case, together with a short medical report, is referred back to the Associated Tuberculosis Dispensary to be dealt with.

N.B.—For after-care of persons on discharge after Institutional Treatment, see Tuberculosis Officer's duties (No. 25, p. 40).

F.—ARRANGEMENTS FOR THE TRANSFER OF INSURED TUBERCULOUS PERSONS FROM ONE DISTRICT TO ANOTHER.

These cases come under the following headings :—

- (a) Those under treatment by the panel doctor.
- (b) Those under treatment at a Tuberculosis Dispensary (inside or outside a hospital.)
- (c) Those under treatment in a Hospital (general or special), in-patient department.
- (d) Those under treatment in a Sanatorium.
- (e) Those under treatment in an Institution for the Treatment of Advanced Cases.

Case (a) or (b) is referred to the Tuberculosis Dispensary of the district in which the patient is going to reside, together with the Medical Record of the case.

Case (c) is referred from the hospital to the Tuberculosis Dispensary of the district in which the patient is going to reside, together with a short medical report to the Tuberculosis Officer, who shall deal with the case accordingly.

Case (d) or (e) is referred from the sanatorium or institution for advanced cases to the Tuberculosis Dispensary of the district in which the patient is going to reside, and the Tuberculosis Officer of the Tuberculosis Dispensary concerned shall deal with the case accordingly.

N.B.—The London Insurance Committee must immediately send the names and new addresses of all transferred patients to the Local Insurance Committee concerned, which must then communicate with the Tuberculosis Dispensary of that district, with regard to the patient's treatment. Hence each Tuberculosis Dispensary must act as a bureau for the various districts of a borough or for a whole borough, as a means of keeping in touch with transferred Tuberculous Persons.

UNINSURED PERSONS.

CONTENTS.

- (A) Persons presenting themselves to the general practitioner, including the Poor Law medical officer.
- (B) Persons presenting themselves at a General or Chest Hospital, with a Tuberculosis Dispensary, which hospital may act as an Affiliated Hospital Centre.
 - (1) Out-patient department, and general dispensary.
 - (a) Cases sent up by the general practitioner.
 - (b) Cases coming up by hospital admission letters.
 - (2) In-patient department.
 - (a) Beds ... { London County Council (or Borough Council).
Voluntary.
 - (b) Observation { From the Tuberculosis Dispensary.
beds { „ Affiliated Tuberculosis Dispensaries.
 - (3) Tuberculosis Dispensary, or Department for the Prevention of Consumption.
 - (a) Cases sent in by the Medical Officer of Health, for diagnosis and treatment.
 - (b) Cases sent in by the general practitioner, including the Poor Law medical officer.
 - (c) Cases coming independently.
 - (d) Cases sent by Voluntary Agencies.
 - (e) Cases diagnosed as tuberculous from Observation Wards.
 - (f) Cases sent up from an Affiliated Tuberculosis Dispensary.
 - (i) Cases for diagnosis.
 - (ii) Cases for special treatment.
 - (g) Cases discharged after Institutional Treatment.
 - (h) Transferred cases from other districts.
 - (i) Contact cases.

- (C) Persons presenting themselves at a Tuberculosis Dispensary (outside a hospital).
- (a) Cases sent by the Medical Officer of Health.
 - (b) Cases sent by the general practitioner, including the Poor Law medical officer.
 - (c) Cases coming independently.
 - (d) Cases sent by Voluntary Agencies.
 - (e) Cases discharged after Institutional Treatment.
 - (f) Transferred cases from other districts.
 - (g) Contact cases.
- (D) Persons presenting themselves at a Tuberculosis Dispensary inside a general dispensary.
(Subdivisions as in (C).)
- (E) Persons presenting themselves at a general or chest hospital, without a Tuberculosis Dispensary, or at an ordinary general dispensary.
- (a) Out-patient department $\left\{ \begin{array}{l} \text{Case found tuberculous.} \\ \text{Diagnosis doubtful.} \end{array} \right.$
 - (b) In-patient department :—
 - 1. $\left\{ \begin{array}{l} \text{(a) London County Council (or Borough} \\ \text{Council) beds.} \\ \text{(b) Voluntary beds.} \end{array} \right.$
 - 2. Observation beds.
- (F) Persons presenting themselves at the workhouse infirmary hospital.
- (1) Cases sent in by the Poor Law relieving officer.
 - (2) Cases sent in as tuberculous by the Poor Law medical officer, for treatment in the infirmary hospital.
 - (3) Cases from the Tuberculosis Dispensary recommended for Institutional Treatment at the workhouse infirmary hospital by decision of the Medical Officer of Health.
- (G) Transferred uninsured Tuberculous Persons.
- (H) After-care of persons discharged after Institutional Treatment.

UNINSURED PERSONS.

A.—PERSONS PRESENTING THEMSELVES TO THE GENERAL PRACTITIONER, INCLUDING THE POOR LAW MEDICAL OFFICER.

The case is examined, and found tuberculous ; it is then notified to the Medical Officer of Health.

The case is classified by the general practitioner for appropriate

treatment, *i.e.*, Sanatorium, Hospital, Tuberculosis Dispensary, Domiciliary, etc.

According to the wishes of the general practitioner, in all such cases a consultation can be arranged with the Tuberculosis Officer of the Tuberculosis Dispensary for diagnosis, classification, treatment, etc.

If the patient is unable to pay for ordinary medical attendance, he shall be referred to the district Tuberculosis Dispensary for treatment.

If Institutional Treatment in a sanatorium, hospital, or institution for advanced cases is recommended, a consultation should be arranged between the Tuberculosis Consulting Physician, Tuberculosis Officer, and general practitioner (should the Tuberculosis Dispensary be a department of a general or special hospital), or between the Tuberculosis Officer and the general practitioner (should the Tuberculosis Dispensary be outside an institution), and then, unless the patient refuses such treatment, a report of the decision come to at the consultation, together with the Medical Record, must be forwarded to the Medical Referee for a final judgment.

The Medical Officer of Health asks the Tuberculosis Officer to make arrangements, through the Tuberculosis Nurse, for the examination and re-examination of Contacts, which must take place at the Tuberculosis Dispensary, except under special circumstances, *i.e.*, if the patient is too ill to attend, or if the conditions of his work will not permit of attendance during the day-time.

If, after examination, the Tuberculosis Officer finds one or more of these Contacts suffering from Tuberculosis, he classifies, notifies to the Medical Officer of Health, and, if Domiciliary Treatment is recommended, refers to the general practitioner those persons who are able to pay, while those persons who are unable to pay are dealt with at the district Tuberculosis Dispensary by the Tuberculosis Officer.

If Institutional Treatment is recommended, the case, together with the Medical Record, is referred to the Medical Referee for final decision.

Cases recommended through the Tuberculosis Dispensary for Segregation Treatment in :—

(a) *Hospital wards for advanced cases.* Recommendation for these must come from the Medical Referee at the Central Bureau.

(b) *Special Institutions for advanced cases.* Recommendation for these must come from the Medical Referee at the Central Bureau.

(c) *Poor Law Infirmary Hospital.* Recommendation for this must come from the Medical Referee through the Metropolitan Asylums Board, or Board of Guardians.

B.—PERSONS PRESENTING THEMSELVES AT A GENERAL OR CHEST HOSPITAL WITH A TUBERCULOSIS DISPENSARY (WHICH HOSPITAL MAY ACT AS AN AFFILIATED HOSPITAL CENTRE).

(1) **Out-patient department.**

The case is examined, and if found tuberculous, is classified, and notified to the Medical Officer of Health of the Tuberculosis Dispensary area in which the patient resides (if this has not already been done).

The Medical Officer of Health makes arrangements for the examination and re-examination of Contacts. (See A, p. 22.)

(a) *Cases sent up by the general practitioner.*

If able to pay, the patient is referred back to the general practitioner, together with a short medical report.

If unable to pay, a short medical report is sent to the general practitioner and the case itself is referred to the Tuberculosis Dispensary, together with a medical report.

If the patient does not reside in the hospital area, the procedure is the same as in both the above cases, except that, if unable to pay, he is referred to the Tuberculosis Dispensary of his area, instead of to the hospital Tuberculosis Dispensary.

(b) *Cases coming up by hospital out-patient admission letters.*

The case is examined by the Resident Medical Officer, and if found tuberculous, notified to the Medical Officer of Health.

If able to pay, the patient is referred to a general practitioner of his area, together with a short medical report.

If unable to pay, the case is referred to the hospital Tuberculosis Dispensary, together with a short medical report.

If the patient does not reside in the hospital area, the procedure is the same as in both the above cases, except that, if unable to pay, he is referred to the Tuberculosis Dispensary of his area, together with a short medical report, and notified to the Medical Officer of Health concerned.

N.B.—In all the above cases, the patient, if unable to pay, may attend the out-patient department of the hospital where he was first examined.

(2) **In-patient department.**

(a) Beds	...	{ London County Council (or Borough Council). Voluntary.
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London County Council or Borough Council beds.—The case may be sent in (1) from the out-patient and special departments, through the

Tuberculosis Dispensary and through the Central Bureau, and (2) from the Tuberculosis Dispensary itself, through the Central Bureau.

Voluntary beds.—The case may present itself with a hospital letter for admission.

From whatever channel the case comes up to the hospital, it is examined by the Resident Medical Officer, and, if found tuberculous, is admitted, and notified to the Medical Officer of Health of the hospital borough, and also to the Medical Officer of Health of the patient's Tuberculosis Dispensary borough (should these not be identical).

The latter Medical Officer of Health sends to the nearest Tuberculosis Dispensary a note asking for the examination of Contacts. (See A, p. 22.)

On the patient's discharge from the hospital, the Tuberculosis Officer of his Tuberculosis Dispensary area is informed, and the Medical Record of the case is sent to the Tuberculosis Officer by the Resident Medical Officer.

(b) Observation bed cases. (London County Council, or Borough Council.)

Cases from the Tuberculosis Dispensary itself.—If a case turns out to be tuberculous, it is notified to the Medical Officer of Health of the district concerned, who makes the usual arrangements for contacts. (See A.) The case itself is referred to the hospital Tuberculosis Dispensary to be dealt with accordingly. (See B (3), Section (a).)

If a case is found non-tuberculous, it is sent back to the Tuberculosis Dispensary to be dealt with.

Cases from the Affiliated Tuberculosis Dispensaries.—A case, whether tuberculous or not, is referred back to the Affiliated Tuberculosis Dispensary, through the Hospital Tuberculosis Dispensary, together with a medical report. The Tuberculosis Officer of the Affiliated Tuberculosis Dispensary shall deal with the case accordingly. (See C.)

B.—(3) Tuberculosis Dispensary, or the Department for the Prevention of Consumption.

Uninsured persons may present themselves as follows :—

- (a) From the Medical Officer of Health, for diagnosis and treatment.
- (b) From the general practitioner, including the Poor Law medical officer.
- (c) Independently, by Tuberculosis Dispensary admission cards.
- (d) From Voluntary Agencies, by Tuberculosis Dispensary admission cards.
- (e) From the Observation Wards (in-patient department).

(f) From an Affiliated Tuberculosis Dispensary, for diagnosis or special treatment.

(g) On discharge, after Institutional Treatment.

(h) As transferred cases from other districts.

(i) As "Contacts" for examination and re-examination.

From whatever channel the case may come, the patient's "Case-Record-Notes" are taken by the Tuberculosis Nurse—unless this has been done already—*i.e.*, name, address and circumstances of family, etc. The case is scheduled and classified as "able to pay," or "unable to pay." Immediately after the first visit of the patient, arrangements are made by the Tuberculosis Nurse for the examination of Contacts by the Tuberculosis Officer of the Tuberculosis Dispensary.

(a) *Cases sent in by the Medical Officer of Health, for diagnosis and treatment.* The case is examined by the Tuberculosis Officer and, if found tuberculous, is notified to the Medical Officer of Health, who makes the usual arrangements for Contacts. (See A.)

If the patient is recommended Domiciliary Treatment and able to pay, he is referred to his general practitioner, or, if he has none, then he is referred to one in his area.

If unable to pay, he is treated at the Tuberculosis Dispensary, or, if other treatment is advised, arrangements will be made by the Tuberculosis Officer.

If Institutional Treatment (in a sanatorium, hospital or institution for advanced cases) is recommended by the Tuberculosis Officer, a consultation is arranged with the Tuberculosis Consulting Physician and the general practitioner (if the patient is being attended by one).

If the Tuberculosis Consulting Physician's decision is not accepted by the general practitioner or patient, the case, together with the Medical Record, is referred for final judgment and decision to the Medical Referee at the Central Bureau.

If the Tuberculosis Officer's decision as to the form of treatment is corroborated by the Tuberculosis Consulting Physician, and it is the wish of the patient that it should be obtained, then the Medical Record of the case, together with a note as to the form of treatment advised, shall be forwarded to the Medical Referee for his final judgment and decision.

The Tuberculosis Officer, on the advice of the Tuberculosis Consulting Physician, may, after examination, refer any case for diagnosis, to the Observation Wards of the hospital, but the Central Bureau must be informed.

Cases for Special Treatment (surgical, etc.). London County Council or Borough Council beds.

The Tuberculosis Officer must, on special form provided, note the form of treatment desired, and where it is to be carried out, and send this form, together with the clinical notes of the case, to the Medical Referee for final decision, and if granted, arrangements for treatment shall be made accordingly.

Emergency Cases (as Hæmoptysis, Pneumothorax, Acute Spread, etc.).

The Tuberculosis Officer shall have the power of sending cases direct to the hospital beds, notifying the Central Bureau immediately.

(b) *Cases sent in by the general practitioner including the Poor Law medical officer.* Procedure as in B (3), Section (a), except that the case must be examined by the Tuberculosis Consulting Physician.

Where possible, examination is made in consultation with the general practitioner, but if the latter is unable to be present, a short medical report is to be immediately sent to him.

Treatment of Contacts is as in A.

(c) and (d). *Cases coming independently, or by Voluntary Agencies.* The case is examined, and if found tuberculous, is notified to the Medical Officer of Health of the patient's borough, who makes the usual arrangements for the examination of Contacts.

Procedure as in B (3), Section (a).

If the patient does not reside in the Tuberculosis Dispensary area, he is examined, and, if found tuberculous, is notified to the Medical Officer of Health of his borough, and a short medical report is sent to the Tuberculosis Dispensary of the patient's area, where the Tuberculosis Officer deals with the case according to the form of treatment recommended. (See B (3), Section (a).

(e) *Cases diagnosed as tuberculosis from the Observation Wards.* The case is notified by the Tuberculosis Officer, to the Medical Officer of Health of the patient's borough, who makes the usual arrangements for contacts. (See A.)

Procedure as in B (3), Section (a).

(f) *Cases sent up from an Affiliated Tuberculosis Dispensary outside an institution.*

(i) Cases for diagnosis.

If the Tuberculosis Consulting Physician's opinion on the case is definite, the case is referred to the Affiliated Tuberculosis Dispensary to be dealt with, together with a short medical report.

Contacts are arranged for at the Affiliated Tuberculosis Dispensary.

If the case is doubtful, the Tuberculosis Officer, on the advice of the

Tuberculosis Consulting Physician, may refer it to the Observation Wards for diagnosis. If the diagnosis is made here, the case is referred to the Affiliated Tuberculosis Dispensary, through the hospital Tuberculosis Dispensary to be dealt with.

“Contacts” are arranged for at the Affiliated Tuberculosis Dispensary.

(ii) *Cases for Special Treatment.* (Surgical, Throat, etc.)

Arrangements are made by the Resident Medical Officer of the hospital through the Central Bureau for this to be carried out. The case is notified by the Resident Medical Officer to the Medical Officer of Health of the district.

(g) *Cases discharged after Institutional Treatment.* Such cases, after examination and consideration of the Medical Records, are dealt with accordingly.

(h) *Transferred Cases from other districts.* (See G.)

(i) *Cases coming as “Contacts.”* (See A.)

N.B.—Opportunities shall also be granted by the Tuberculosis Dispensary authorities for certain privileged persons to make use of the Medical Records at the Tuberculosis Dispensary for purposes of research in Tuberculosis.

C.—PERSONS PRESENTING THEMSELVES AT A TUBERCULOSIS DISPENSARY OUTSIDE A HOSPITAL.

Uninsured persons may present themselves as follows :—

(a) From the Medical Officer of Health, for diagnosis and treatment.

(b) From the general practitioner, including the Poor Law medical officer.

(c) Independently, by Tuberculosis Dispensary admission cards.

(d) From Voluntary Agencies, by Tuberculosis Dispensary admission cards.

(e) On discharge, after Institutional Treatment.

(f) As transferred cases from other districts.

(g) As “Contacts,” for examination and re-examination.

From whatever channel the case may come, the patient’s “Record-Notes” are taken by the Tuberculosis Nurse—unless this has been done already—*i.e.*, name, address and circumstances of family, etc. The case is scheduled and classified as “able to pay” or “unable to pay.” Immediately after the first visit of the patient, arrangements are made by the Tuberculosis Nurse for the examination of Contacts by the Tuberculosis Officer of the Tuberculosis Dispensary.

(a) Cases sent by the Medical Officer of Health.

(b) Cases sent by the general practitioner (including the Poor Law medical officer).

(c) and (d) Cases coming independently, or by Voluntary Agencies.

From whatever channel the case may come, the procedure is the same as in the cases referred to under B (3), sections *a*, *b*, *c*, and *d*, except that, when Institutional Treatment is recommended by the Tuberculosis Officer, the case is referred direct from him to the Medical Referee at the Central Bureau, unless there should arise a doubt as to the diagnosis, or a disagreement in the diagnosis between the Tuberculosis Officer and general practitioner, when the case may be referred to the Tuberculosis Consulting Physician of an Affiliated Hospital, should there be one.

If there is no Affiliated Hospital, the case is referred direct to the Medical Referee for his decision.

In all the above cases, after examination, the Tuberculosis Officer may, if necessary, refer the case for diagnosis to the Observation Wards of the Affiliated Hospital, through the Tuberculosis Officer and Tuberculosis Consulting Physician of that hospital. (See B (3), Section *f*.)

If there is no Affiliated Hospital with a Tuberculosis Dispensary, but an Associated Hospital without a Tuberculosis Dispensary, the Tuberculosis Officer of the Associated Tuberculosis Dispensary may refer any case for diagnosis to the Observation Wards of the latter hospital, after making arrangements with the Central Bureau for the admission of the case.

(e) Cases discharged after Institutional Treatment.

Such cases, after examination and consideration of the Medical Records, are dealt with accordingly.

(f) Transferred cases from other districts. (See Section G.)

(g) Cases coming as Contacts. (See Section A.)

N.B.—Opportunities shall also be granted by the Tuberculosis Dispensary authorities for certain privileged persons to make use of the Medical Records at the Tuberculosis Dispensary for purposes of research in Tuberculosis.

D.—PERSONS PRESENTING THEMSELVES AT A TUBERCULOSIS DISPENSARY INSIDE A GENERAL DISPENSARY.

Cases may present themselves as follows :—

(1) From the Medical Officer of Health, for diagnosis and treatment.

(2) From the general practitioner, including the Poor Law medical officer.

(3) Independently, by Tuberculosis Dispensary admission cards.

(4) From Voluntary Agencies, by Tuberculosis Dispensary admission cards.

(5) On discharge, after Institutional Treatment.

(6) As transferred cases from other districts.

(7) As "Contacts," for examination and re-examination.

From whatever channel the case may come, the patient's "Record-notes" are taken by the Tuberculosis Nurse, unless this has been done already, *i.e.*, the name, address and circumstances of family, etc. The case is scheduled and classified as "able to pay" or "unable to pay." Immediately after the first visit of the patient, arrangements are made by the Tuberculosis Nurse for the examination of Contacts by the Tuberculosis Officer of the Tuberculosis Dispensary.

(1) Cases sent in by the Medical Officer of Health for diagnosis and treatment.

The case is examined by the Tuberculosis Consulting Physician, and, if tuberculous, is notified to the Medical Officer of Health, who makes the usual arrangements for Contacts. (See A.)

If the patient is recommended Domiciliary Treatment, and if able to pay, he is referred to his general practitioner, or, if he has none, then he is referred to one in his area.

If unable to pay, he is treated at the Tuberculosis Dispensary, or, if other treatment is advised, arrangements will be made by the Tuberculosis Consulting Physician.

If the patient is recommended Institutional Treatment, the case is referred by the Tuberculosis Consulting Physician to the Medical Referee at the Central Bureau, for his decision.

The Tuberculosis Officer, on the advice of the Tuberculosis Consulting Physician, may refer any case for diagnosis to the Observation Wards of the Affiliated Hospital, through the Tuberculosis Dispensary of that Hospital, but the Central Bureau must be informed.

If there is no Affiliated Hospital with a Tuberculosis Dispensary but an Associated Hospital without a Tuberculosis Dispensary, the Tuberculosis Officer of the Associated Tuberculosis Dispensary may refer any case for diagnosis to the Observation Wards of the latter hospital, after making arrangements with the Central Bureau for the admission of the case.

(2) Cases sent by the general practitioner (including the Poor Law medical officer.)

Procedure as in D (1), and where possible, examination is made in consultation with the general practitioner, but if the latter is unable to be present, a short medical report is to be immediately sent to him.

Treatment of Contacts is as in A.

(3) and (4) *Cases coming independently or by Voluntary Agencies, with Tuberculosis Dispensary admission cards.*

The case is examined by the Tuberculosis Officer, and if found tuberculous, notified to the Medical Officer of Health of the patient's borough, who makes the usual arrangements for Contacts.

If the patient is recommended Domiciliary Treatment, see D, Section (1).

If the patient is recommended Institutional Treatment, a consultation is arranged with the Tuberculosis Consulting Physician. The Tuberculosis Officer, if the Tuberculosis Consulting Physician corroborates his opinion, refers the case for final decision to the Medical Referee at the Central Bureau.

For reference to the Observation Wards of the Affiliated or Associated Hospital, see D (1).

If the patient does not reside in the Tuberculosis Dispensary area, he is examined, and if tuberculous is notified to the Medical Officer of Health of his borough, and a short medical report is sent to the Tuberculosis Dispensary of the patient's area, where the Tuberculosis Officer deals with the case according to the form of treatment recommended. (See B (3), Section a.)

(5) *Cases discharged after Institutional Treatment.*

Such cases, after examination, and consideration of the Medical Records, are dealt with accordingly.

(6) *Transferred cases from other districts.* (See Section G.)

(7) *Cases coming as "Contacts."* (See Section A.)

N.B.—In all cases opportunities shall be granted by the Tuberculosis Dispensary authorities for certain privileged persons to make use of the Medical Records at the Tuberculosis Dispensary for purposes of research in Tuberculosis.

E.—PERSONS PRESENTING THEMSELVES AT A GENERAL OR CHEST HOSPITAL, WITHOUT A TUBERCULOSIS DISPENSARY, OR AT AN ORDINARY GENERAL DISPENSARY (NO IN-PATIENTS).

(a) **Out-patient department** (or general dispensary). The case is examined, and

(1) If found tuberculous, it is classified and notified to the Medical Officer of Health of the patient's borough, who makes arrangements with the Tuberculosis Officer of the Tuberculosis Dispensary of that borough, for the examination and re-examination of Contacts. (See A.)

If the patient belongs to the hospital borough :

If able to pay, he is referred to the general practitioner with a short medical report.

If unable to pay, he is referred for treatment to the Tuberculosis Dispensary of the hospital borough, with a medical report of the case.

If the patient resides outside the hospital borough :

If able to pay, he is referred to a general practitioner of his borough, through the Tuberculosis Dispensary concerned.

If unable to pay, he is referred to the Tuberculosis Dispensary of his borough (wherever it may be) together with a medical report of the case, and is dealt with accordingly.

The patient may, however, if he so desires, and it is in accordance with the hospital rules and regulations, attend the out-patient department of the hospital, where he was first examined.

(2) If the case is examined and the diagnosis is doubtful, the out-patient physician has two courses open to him.

He may send the case into the in-patient department (Voluntary Beds) for observation. (See E (b), Section (2).)

He may refer the case, together with a short medical report, to the Tuberculosis Dispensary of the patient's district, to be dealt with.

N.B.—If a patient, after observation, is found to be tuberculous, and able to pay, he is notified to the Medical Officer of Health concerned, who makes arrangements for Contacts, and the case itself is referred to the general practitioner concerned, to be dealt with (either directly or through a Tuberculosis Dispensary).

(b) In-patient department :

(1) Beds for treatment { London County Council (or
Borough Council).
Voluntary.

London County Council (or Borough Council) beds.

(i) For ordinary or special treatment. Cases are admitted from the Associated Tuberculosis Dispensaries through the Central Bureau, and notified to the Medical Officer of Health of the hospital borough. On discharge, the patient is referred back to the Associated Tuberculosis Dispensary to be dealt with.

Arrangements are made for Contacts, if this has not already been done.

(ii) For emergency treatment. The Tuberculosis Officer of the Associated Tuberculosis Dispensary has the power of sending cases direct to the emergency beds, but he must immediately notify the Medical Referee of the Central Bureau.

Voluntary Beds. Cases may present themselves with hospital letter for admission, or from the out-patient or special departments.

hospital. After discharge, the patient is referred to the Tuberculosis Dispensary of the district in which he is going to reside, and a medical report is sent to that Tuberculosis Dispensary.

G.—ARRANGEMENTS FOR THE TRANSFER OF UNINSURED TUBERCULOUS PERSONS FROM ONE DISTRICT TO ANOTHER.

These cases come under the following headings :—

(a) Those under treatment by the general practitioner.

(b) Those under treatment at a Tuberculosis Dispensary (inside or outside a hospital).

(c) Those under treatment in a Hospital (general or special), in-patient department.

(d) Those under treatment in a Sanatorium.

(e) Those under treatment in an Institution for Advanced Cases.

(f) Those under treatment in the Poor Law infirmary hospital.

Case (a) or (b) is referred to the Tuberculosis Dispensary of the district in which the patient is going to reside, together with the clinical notes of the case.

Case (c) is referred from the hospital to the Tuberculosis Dispensary of the district in which the patient is going to reside, together with a short medical report to the Tuberculosis Officer, who shall deal with the case accordingly.

Case (d), (e) or (f) is referred from the sanatorium, institution for advanced cases, or Poor Law infirmary hospital respectively to the Tuberculosis Dispensary of the district in which the patient is going to reside, and the Tuberculosis Officer of the Tuberculosis Dispensary concerned shall deal with the case accordingly.

H.—AFTER-CARE OF PERSONS ON DISCHARGE FROM THE SANATORIUM, HOSPITAL, POOR LAW INFIRMARY HOSPITAL, OR SEGREGATION INSTITUTION.

Persons able to attend the Tuberculosis Dispensary :

(a) If the patient is able to pay, the Domiciliary and Emergency Treatment is handed over to the general practitioner, but by special request of the latter, the case may be treated at the Tuberculosis Dispensary.

(b) If the patient is unable to pay, the case is treated at the Tuberculosis Dispensary.

Persons unable to attend the Tuberculosis Dispensary :

(a) If the patient is able to pay, the treatment is handed over to the general practitioner. (b) If the patient is unable to pay, such after-treatment (including Emergency Treatment) as is necessary, must be carried out by the Poor Law medical officer.

Scheme for the Diagnosis and Treatment of Tuberculosis among School Children.

INTRODUCTION.

THAT A THOROUGH ORGANIZATION BE PROVIDED.

(1) By means of which, school children, in whom, after examination by the school medical officer, Tuberculosis is suspected or diagnosed, shall be referred for examination to the Tuberculosis Dispensary, or Department for the Prevention of Consumption in a general or chest hospital. (See B, Section 3, Uninsured, p. 24.)

(2) Whereby arrangements shall be made for obtaining, where possible, that form of treatment recommended for each case of Tuberculosis.

(3) By means of which, arrangements shall be made, if not already carried out, for the examination and re-examination of "Contacts." (See Section A, Uninsured).

SCHEME.

That every Department for the Prevention of Consumption, or Tuberculosis Dispensary, shall be regarded as a clearing-house for all forms of Tuberculosis.

(1) DIAGNOSIS.

(a) Cases in which Pulmonary Tuberculosis is suspected or diagnosed.

(b) Cases in which Tuberculosis other than Pulmonary is suspected or diagnosed.

(2) TREATMENT.

(a) Determination as to the most suitable form of treatment for each case of Tuberculosis, and arrangements made, by means of an organized system, for this to be carried out.

(b) A Treatment Centre for certain specified cases of Tuberculosis.

DIAGNOSIS.

(A) AT THE TUBERCULOSIS DISPENSARY.

(1) Examination of doubtful cases of Pulmonary Tuberculosis sent by the school medical officers or medical attendants concerned :—

(a) Clinical examination	...	...	}	One or more of these methods of examination may be necessary.
(b) X-ray (screen)	...	...		
(c) Sputum examination	...	...		
(d) Tuberculin test, <i>i.e.</i> , von Pirquet				

(2) Examination of cases other than pulmonary—suspected or diagnosed as Tuberculosis.

(3) Examination of "Contacts." An organized system instituted, to obtain information as to whether or not this examination has been made; if not, to arrange when possible, for such examination by the Local Tuberculosis Dispensary or otherwise. (See A, Uninsured.)

N.B.—A special endeavour ought to be made by the authorities concerned, to arrange for the presence of the mother, or, failing her, the father (although his presence is not nearly of so much importance), at the clinical examination of the child, at times suitable to their convenience. Practical experience of this work teaches us that the presence of the mother is almost a necessity at such examination, and that any scheme for the clinical examination of these children should include a thorough organization to obtain this.

(B) WITHIN THE HOSPITAL.

Observation Beds. (See B (2), Section (b) Uninsured.) For cases not definitely cleared up in the Tuberculosis Dispensary.

Special clinical examination	{	(a) Physical examination	...	{	One or more of these methods accordingly.
		(b) Temperature records	...		
		(c) Bacteriological examination	...		
		(d) Tuberculin tests	...		
		(e) X-ray examination...	...		

TREATMENT.

(A) AT THE TUBERCULOSIS DISPENSARY.

(1) Cases of Pulmonary Tuberculosis attending school (ordinary, open-air, or Tuberculosis school), and which may be appropriately treated at a Tuberculosis Dispensary.

(2) Cases of Pulmonary Tuberculosis (advanced) living at home, not attending school, and for whom Dispensary Treatment is appropriate.

(3) Tuberculous cases other than Pulmonary. (Only when suitable for such treatment.)

(a) Bones and joints.

(b) Skin.

(c) Abdominal Tuberculosis.

(d) Other forms of Tuberculosis.

(B) WITHIN THE HOSPITAL.

(1) Cases of Acute Pulmonary Tuberculosis. (Early cases.)

(2) Cases of Pulmonary Tuberculosis with complications or urgent symptoms, such as:—

- (a) Adenoids and tonsils (only when necessary).
- (b) Hæmoptysis (severe).
- (c) Pleurisy.
- (d) Empyema.
- (e) Intestinal ulceration.
- (f) Meningitis.
- (g) Pneumothorax.
- (h) Fistula.
- (i) Bronchiectasis, etc.
- (3) Cases of Tuberculosis other than Pulmonary.
 - (a) Surgical Tuberculosis. Bones and joints, only if suitable for operative treatment.
 - (b) Other forms of Tuberculosis. Of skin or abdomen.

(C) TREATMENT ELSEWHERE.

e.g., At a Sanatorium, Tuberculosis School, Open-air School, Home Infirmary or Hospital (such as the Hospital at Alton).

FACTS IN SUPPORT OF THE SCHEME FOR SCHOOL CHILDREN.

MEDICAL.

(1) The great difficulties in the Diagnosis of Pulmonary Tuberculosis amongst children.

(2) Special experience of Pulmonary Tuberculosis in children is necessary for accurate diagnosis.

(3) The nature of the clinical examination required in each case usually demands more time than can be given by the school medical officer, however experienced he may be.

The frequency with which these cases have in the past been referred to general and chest hospitals for an opinion, and the experience of those who have themselves been school medical officers, support this contention.

(4) In most cases more than one clinical examination is necessary to make a "definite diagnosis."

(5) In certain cases the importance of an X-ray examination, and of the occasional use of Tuberculin Tests for diagnosis cannot be overlooked, and owing to the circumstances these cannot be satisfactorily carried out at the school examination.

(6) The value of the work, if well done, in conjunction with the system of medical examination of school children now instituted in the

London County Council schools, would prove one of the greatest factors in that campaign against Tuberculosis, by eliciting the obvious and latent cases of Tuberculosis amongst children, and by making arrangements for their treatment; again, by pursuing the investigation further, into the homes of the children, and so bringing to light the cases of Tuberculosis lurking there. This work can only be accomplished by a well-organized system.

(7) In the experience of some physicians who are in a position to form an unbiased judgment, there is definite evidence to prove that a fair percentage of children are at present being diagnosed and notified as suffering from Pulmonary Tuberculosis, on insufficient grounds. The converse is also true. It is reasonable to state that no physician is justified in giving a definite diagnosis of Pulmonary Tuberculosis in a child, and more particularly in notifying the same, unless he has conclusive evidence on which to base his opinion. That a child has been definitely diagnosed and notified as suffering from Pulmonary Tuberculosis, is a matter of momentous importance to that child.

(8) Last, but not least, an endeavour to obtain by accurate scientific methods the incidence of Tuberculosis, and more especially of Pulmonary Tuberculosis amongst children, so as to enable us to clear up one of the great problems which yet remain, namely:—

- (a) The sources of infection, the order in time of their occurrence, and the ages at which they take place.
- (b) To obtain from this information the best means to enable us to prevent infection, on a sound economic basis.

ECONOMIC.

(1) Good scientific work in diagnosis and treatment done at a reasonable and minimum cost.

(2) An endeavour to save, at least a part of the* £30,000 annually

* During the past decennium, the London Education Authority has expended over £30,000 annually for the education of children who have died from Tubercle before attaining adult working life.

In ten years (1900-09) £327,185 was spent on the education of those dying of tubercular disease. This was money almost lost, as the children died before they had passed out of their 'teens, and, therefore, never made any adequate return for it. The estimate does not make any allowance for the cases who survived crippled, or in chronic ill-health. If the deaths are so numerous, it may be assumed that the ill-health without death is extremely costly to the community.

(London County Council Education Departmental Report, 1911. Dr. James Kerr.)
(S. Letitia Fairfield's Work. From the Registrar-General's figures.)

spent on the education of Tuberculous Children in London, who die before they can in any way recompense the State.

(3) By doing good preventive work, and so saving the rates.

Good scientific work done on which to base practical legislation:—

Good scientific work done in connection with these children would be almost certain to evolve facts on which could be based practical legislation for the prevention and treatment of Tuberculosis.

DUTIES OF THE TUBERCULOSIS OFFICER.

In Connection with a Tuberculosis Dispensary (outside of a Hospital).

(1) He must make himself responsible for the whole work of the Tuberculosis Dispensary, and examine all new cases and all Contacts, unless this has been already done.

(2) He must notify all cases to the Medical Officer of Health of the patient's borough.

(3) He must supervise the Tuberculosis Nurse's work in connection with the drawing up of the Nurse's report, and see that a duplicate is regularly sent to the Medical Officer of Health of the borough.

(4) He must arrange for the reference of suitable cases for diagnosis, treatment (Hospital), etc., to the Affiliated Hospital centre.

(5) He must see that insured cases referred to his Tuberculosis Dispensary from hospitals, sanatoria or other institutions for Domiciliary Treatment, are referred to the panel doctors concerned.

(6) He must keep a record of all cases requiring assistance from the voluntary agencies, and transmit the same to the latter.

(7) He must examine the Contacts at the Tuberculosis Dispensary, wherever possible; if not possible at the Tuberculosis Dispensary, it must be done at the homes, and the Tuberculosis Officer must endeavour to arrange for the re-examination of Contacts every six months.

(8) He must endeavour to instruct the people of his Tuberculosis Dispensary area in matters of Public Health and Hygiene in relation to Tuberculosis, by lectures, diffusion of literature, etc.

(9) He must arrange, when possible, clinical demonstrations for practitioners of his district, and afford them every facility for the practical study of Tuberculosis.

(10) He must keep a correct statistical record of all cases, and prepare a quarterly report for the Medical Officer of Health and Tuberculosis Committee.

(11) He must see that accurate records of all cases dealt with at the Tuberculosis Dispensary are filed and indexed as to the patients' names

and addresses in the Tuberculosis Dispensary areas, which the Tuberculosis Dispensary serves.

(12) As far as Public Health is concerned, he must keep in intimate touch with the Public Health Authorities, *i.e.*, the Borough Council, through association with the Medical Officer of Health, recognizing the great importance of welding the link between the Tuberculosis Dispensary and these authorities.

(13) He must consult with the panel doctors and general practitioners over their cases, as may be required.

(14) He must make arrangements for the examination of sputa and other secretions, and send them to the bacteriological laboratories for examination and report.

(15) He should keep in touch, by every possible means, with the latest work in Tuberculosis, theoretically and practically, and keep himself abreast of modern medicine.

(16) He must see that his Department acts as a bureau for sending cases to the various institutions to which they have been relegated after classification of treatment.

(17) He must take special care that the Medical Records of cases are referred to the various institutions concerned.

(18) He must refer to the Medical Referee those cases which have been recommended for Institutional Treatment (Sanatorium, Hospital, Segregational).

(19) He must arrange with the Metropolitan Asylums Board, or with the Board of Guardians of his borough, for those advanced Poor Law cases recommended by the Medical Referee for treatment in the Poor Law infirmary hospital.

(20) He should, both for his advantage and for advances in Tuberculosis, utilize for research work, any material which is presented to him at the Tuberculosis Dispensary.

(21) He must keep in intimate touch with his cases after they leave the Tuberculosis Dispensary, and at regular intervals a note as to their condition should be entered in the Tuberculosis Dispensary Case Charts (Bureau).

(22) He must do everything in his power to obtain the intimate and thorough co-operation of the practitioners of his district, and endeavour to work in harmony with them, and an up-to-date list of the panel doctors and general practitioners of the borough must be kept at the Tuberculosis Dispensary.

(23) He should keep in mind his duties to the working people and employers of labour, and endeavour to preserve a sympathetic attitude towards their conditions and surroundings.

(24) He shall make a report on the homes, after receipt of the Home Report of the Tuberculosis Nurse. This report, combined with the Tuberculosis Officer's own clinical report, is absolutely necessary for a proper estimate as to the patient's future treatment. The home conditions should be classified as follows:—

- (1) Satisfactory.
- (2) Unsatisfactory.
- (3) Removal urgently necessary.

The final classification of treatment should be based on the following:—

(A) *Medical examination of physical condition to decide as to form of treatment as follows:—*

- (1) Domiciliary Treatment.
- (2) Treatment at the Tuberculosis Dispensary.
- (3) Treatment in the in-patient department.
 - (a) Special treatment for acute disease, or surgical treatment.
 - (b) Emergency treatment.
 - (c) Observation treatment, for diagnosis.
 - (d) Segregation of Advanced Cases.
- (4) Sanatorium.
- (5) Institution for Advanced Cases.
- (6) Workhouse infirmary (uninsured).

(B) *Home and general conditions of the patient to decide as to the form of treatment as follows:—*

- (1) The home in relation to housing, drainage, sanitation, cleanliness, etc.
- (2) The employment of the patient.
- (3) The "Contacts," whether children or not.
- (4) The condition of the patient, *re* alcohol.

(25) In connection with insured persons, the Tuberculosis Officer of the Tuberculosis Dispensary should make special provision for the after-care of persons discharged after Institutional Treatment, on the expiration of their twenty-six weeks' treatment, so that the beneficial results obtained therefrom may not be lost.

(26) In relation to school children, if any such child has a family practitioner in attendance, it shall be the duty of the Tuberculosis Officer to communicate with him with regard to his case.

Duties of the Tuberculosis Officer in a Tuberculosis Dispensary inside a hospital.

In addition to the Tuberculosis Officer's duties at the Tuberculosis Dispensary outside a hospital, as follows:—

(1) He must refer to the Tuberculosis Consulting Physicians all new or old cases on which he requires advice.

(2) He must arrange for the reference of cases to the various special departments of the hospital, including the in-patient and Observation Departments, for diagnosis and treatment. (See B (3).)

(3) He must arrange for the examination and treatment by the Tuberculosis Consulting Physicians of all cases sent up from the Affiliated Tuberculosis Dispensaries, and by the panel doctor or general practitioner.

(4) He must receive all cases referred from the out-patient department (uninsured) and other departments of the hospital, and arrange for their examination and treatment.

DUTIES OF THE TUBERCULOSIS CONSULTING PHYSICIAN.

In a Tuberculosis Dispensary inside a hospital.

(1) He must see all cases (insured and uninsured) referred to him by the Tuberculosis Officer either for diagnosis, treatment, or both, or by the panel doctor or general practitioner, for diagnosis, treatment, or both.

(2) He must examine and classify all cases referred to the Tuberculosis Dispensary for Institutional Treatment.

(3) He must see all cases (insured and uninsured) referred from Affiliated Tuberculosis Dispensaries.

(4) He must use the available clinical material for teaching and also for research purposes—these being regarded as very important duties of the Tuberculosis Consulting Physician.

(5) He must make periodical reports to the Tuberculosis Committee on the working of the Department, and also make suggestions as to any improvements that might be carried out.

(6) He must supervise the work of the Tuberculosis Dispensary, and see that it becomes the bureau of the borough for the keeping of careful and accurate "Case-Records" which must be filed and indexed.

(7) He must supervise the arrangements for the instruction of the people of the district in matters relating to Tuberculosis, by means of lectures, diffusion of literature, etc.

DUTIES OF THE TUBERCULOSIS NURSE.

In the Tuberculosis Dispensary.

(1) She must keep the "Patients' Record Book" accurately and carefully.

(2) She must prepare the patients for examination by the Tuberculosis Officer and the Tuberculosis Consulting Physician, and, if

necessary, for Tuberculin Treatment, and regularly record the patients' weights and enter them on the charts.

(3) She must distribute the thermometers, where required, and instruct the patients in the taking of their temperatures.

(4) She must distribute at the Tuberculosis Dispensary the specimen bottles for the examination of the sputa.

(5) She must prepare the Tuberculosis Nurse's Report of the home conditions of the patient, for presentation to the Tuberculosis Officer.

(6) She must acquire an intimate knowledge of her duties in relationship to the school authorities, voluntary agencies, Medical Officer of Health, and general practitioner, or panel doctor.

In the homes.

(7) She must visit the homes of the new patients, if possible, on the day after their first visits, so as to obtain information to fill up her report (but not to fill up this report at the homes), and see that the Tuberculosis Officer's orders are properly carried out.

(8) She must make arrangements for the examination and re-examination of Contacts at the Tuberculosis Dispensary by the Tuberculosis Officer, or, failing that, at the homes.

(9) She must enlist the aid of the voluntary agencies, where necessary.

(10) She must collect the specimen sputum bottles distributed at the Tuberculosis Dispensary.

(11) She must make arrangements for the re-examination of Contacts (if possible, every six months).

In relationship to the general practitioner.

(12) She must offer her services to the general practitioner who is treating a Tuberculosis case in the home, if he deems such services desirable. If not desired, she is not to interfere in any way with the general practitioner's case.

DUTIES OF THE GENERAL PRACTITIONER.

In relation to the various Tuberculosis Dispensary units.

(1) In relation to the Medical Officer of Health.

He should keep in mind the importance of notifying all Tuberculous Cases to the Medical Officer of Health. Doubtful cases sent to the Tuberculosis Dispensary for diagnosis, and found tuberculous, are notified by the general practitioner, but if the Tuberculosis Officer has already made the notification, such notification fees shall be returned to

the general practitioner concerned. A report as to the Home Conditions shall also be sent to the Medical Officer of Health.

(2) In relation to private patients.

He should give special consideration to the home as regards the correction of unsatisfactory housing conditions, etc.

(3) In relation to the Tuberculosis Dispensary.

He should bear in mind that the Tuberculosis Dispensary is a consultative centre for the diagnosis and special treatment of both insured and uninsured, and that only those uninsured persons are treated at the Tuberculosis Dispensary whose circumstances—medical and financial—will not permit of ordinary medical attendance by the general practitioner.

(4) In relation to voluntary agencies.

He should bring to the notice of the Tuberculosis Dispensary those patients requiring the help of these bodies for food, clothing, etc.

(5) In relation to the Tuberculosis Nurse.

He should keep in mind, in connection with the Domiciliary Treatment of his patients, that the services of the Tuberculosis Nurse are available—from the standpoint of Hygiene and Public Health—when she may be visiting that home.

(6) In relation to "Contacts."

He should endeavour, by every means in his power, to insist on the examination of Contacts of his private tuberculous patients, for which fees ought to be paid. If the family concerned is unable to pay for such examination, and if the practitioner so desires, he may enlist the services of the Tuberculosis Officer and the Tuberculosis Consulting Physician for the purpose, in view of the vital importance of such an examination in the Prevention of Consumption.

The general practitioner can, if he so desires, be associated in consultation with the Tuberculosis Officer in the latter's examination of "Contacts" at the Tuberculosis Dispensary or in the homes.

(7) In relation to the school authorities.

As school children are now examined by the school medical officer, and cases diagnosed as, or suspected to be suffering from Tuberculosis, can be sent to the Tuberculosis Dispensaries to be dealt with, if any such child be a patient of the general practitioner, the latter should receive from the Tuberculosis Officer of the Tuberculosis Dispensary a report as to the patient's condition, and how it is proposed that it should be dealt with. Such patients are dealt with according to the rules laid down for uninsured persons, *i.e.*, referred to the general practitioner if able to pay, and treated at the Tuberculosis Dispensary if unable to pay.

DUTIES OF THE MEDICAL OFFICER OF HEALTH.

Only in relation to the Tuberculosis Dispensary.

(1) In connection with the examination and re-examination of Contacts, on notification of a tuberculous case, he shall communicate with the Tuberculosis Officer of the Tuberculosis Dispensary of his borough, who shall make arrangements accordingly.

(2) He shall receive from the Tuberculosis Dispensary the Tuberculosis Officer's or general practitioner's report of the home conditions on the report of the Tuberculosis Nurse, and, on receipt of this report, deal with any insanitary conditions as he may deem necessary.

(3) On receipt of the Tuberculosis Nurse's Home Report, he shall prepare a short Public Health Report, which shall be immediately sent to the Tuberculosis Officer, for inclusion in the Medical Record of the case concerned.

(4) He shall have the power of referring to the Tuberculosis Dispensaries for diagnosis, treatment, or both, those uninsured Tuberculous Persons unable to pay for ordinary medical attendance.

(5) He shall see that a quarterly report of the work of the Tuberculosis Dispensaries of his borough shall be received from the respective Tuberculosis Officers, and that this report shall be submitted to the Public Health Committee of his borough.

(6) He shall endeavour to attend the meetings of the Tuberculosis Committee of the Tuberculosis Dispensary of his borough, as often as his duties shall permit.

(7) He shall, from time to time, avail himself of his privileges of visiting these Tuberculosis Dispensaries.

METROPOLITAN ASYLUMS BOARD AND BOARD OF GUARDIANS.

(1) The Metropolitan Asylums Board, or Board of Guardians for each borough, as the constituted authority for dealing with Poor Law cases, shall make arrangements for the provision of, and admission to beds for Poor Law cases in the infirmary hospitals, and other institutions, and shall be linked up with the Tuberculosis Dispensaries of the district, for the purpose of dealing with these cases.

(2) The Metropolitan Asylums Board or Board of Guardians shall arrange with the superintendent of the infirmary hospital for the treatment of Tuberculous Cases referred to it by the Poor Law medical officer, or by the Tuberculosis Dispensaries of the borough.

(3) The Metropolitan Asylums Board or Board of Guardians shall

act as the bureau and clearing house for dealing with Poor Law Tuberculous Cases, and, accordingly, an up-to-date list should be kept in its department of all occupied and unoccupied beds in the infirmary hospital.

(4) It is hoped that, in the future, arrangements will be made at the Central Bureau, whereby a department will be formed for the allocation of beds in the institutions dealing with all Tuberculous Poor Law Persons in the County of London.

ADDENDA.

INSURED AND UNINSURED.

(1) The examination and re-examination of Contacts at the Tuberculosis Dispensary. This is of vital importance to all concerned, for the following reasons :—

(a) The contacts will be examined by a Tuberculosis Medical Officer, who has had special experience in Tuberculosis. The value of this examination will be specially appreciated by those who are cognisant of the difficulties in diagnosis. The medical practitioner concerned can attend all such examinations, whenever he wishes to do so.

(b) It obviates the necessity of the Tuberculosis Officer going into the home, unless absolutely essential, and so prevents any interference with the medical practitioner's work there.

(c) It safeguards the interests of the patient with regard to his home conditions and work, as far as is practically possible, *i.e.*, it keeps away the Tuberculosis Officer and Public Health officials, unless such visits are absolutely necessary, thus safeguarding as far as possible the patient's social condition and employment.

(d) The examination at the Tuberculosis Dispensary is likely to be much more thorough than in the homes, and an X-ray examination (screen) can be made in a few minutes. Provision can also be made in certain cases for the minute examination of the sputa. Examination of Contacts by the X-ray is a valuable factor in diagnosis and ought to be carried out as a matter of routine. If this is necessary in the case of adults, it is doubly so in children.

(e) The home conditions are thoroughly investigated by a Tuberculosis Nurse, who is experienced in such work.

(2) Provision should be made for the payment, by the London Insurance Committee, of insured cases sent to Observation Beds from the Tuberculosis Dispensary.

(3) Provision should be made by the London Insurance Committee for payment for the first examination of insured persons at the out-

patient department of a hospital; such examination to include a short medical report to be sent by the out-patient physician on a printed form, to the panel doctor concerned.

(4) Reasons for the necessity of examining all insured cases sent to the out-patient department of a general or special hospital.

From whatever channel the case comes, it should be examined at the out-patient department of the hospital, and if found tuberculous, notified. If the case is doubtful, it should be referred to the panel doctor to be further dealt with. Although no money is at present provided for the examination of insured persons at the out-patient department, it would be most unwise and detrimental to the interests of any Scheme for the Prevention of Consumption to give these persons the opportunity of evading examination for short or long periods, as might well occur if examination were refused on coming to the out-patient department. Hospital experience corroborates this. Failure to notify most cases of Pulmonary Tuberculosis means not only failure to prevent the patient spreading infection in his home and in public places, but also failure to ensure the examination of Contacts, and its far-reaching consequences on the public health.

(5) The reason why a case (uninsured), unable to pay for ordinary medical attendance, and coming to the out-patient department, must be referred for treatment to the Tuberculosis Dispensary of the area concerned, is that money is provided for such treatment by the council of the patient's borough. He may, however, attend the out-patient department of the hospital, for treatment, by hospital letter, if he so wishes, and if his attendance there is conformable to the regulations of the hospital.

(6) All Tuberculous In-patients from a sanatorium, hospital, infirmary hospital or institution for advanced cases, must be notified, not only to the Medical Officer of Health of the patient's borough, but also to the Medical Officer of Health of the sanatorium, hospital, infirmary hospital, or segregation institution borough. This is necessary for the statistical records of the Public Health department of the borough in which the institution is situated.

(7) Great care must be taken to avoid anything that might tend to lower the medical status of the medical practitioner in the eyes of the public, as unwarranted and detrimental to the interests of any Tuberculosis scheme, both preventive and curative.

(8) A complete list should be compiled of the various Tuberculosis Dispensaries of the various boroughs, and their areas served, together with their Affiliated Hospital Centres, the names of the Tuberculosis Consulting Physicians, Tuberculosis Officers and their staffs, and a list

of general practitioners should be kept at the Tuberculosis Dispensary, to whom uninsured persons, able to pay for ordinary medical attendance, and insured persons without a panel doctor, can be referred. A list should be kept also of the panel doctors, the Poor Law medical officers, the officials of the various voluntary agencies of the borough, the officials of the London Insurance Committee and of its sub-committees, and of the Metropolitan Asylums Board, or Board of Guardians.

(9) Hospital (in-patient) cases outside the hospital borough, must undergo a double notification.

(10) The Tuberculosis Officer, on the advice of the Tuberculosis Consulting Physician, has the power of filling the Observation Beds of the hospital, but he must immediately notify the Medical Referee on so doing.

(11) Wherever possible, institutions for advanced cases should be adjuncts or wings of general or special hospitals.

(12) Provision has been made for the examination of both insured and uninsured at the Tuberculosis Dispensary by the panel doctor or general practitioner and at the Central Bureau, as no proper or efficient scheme for the examination of Contacts can be formulated otherwise.

(13) The Local Tuberculosis Dispensaries are to form the pivots for the transference of cases and Medical Records, and on the death of any patient these notes are to be filed at the Tuberculosis Dispensary where he attended before his death.

(14) A printed card of admission to the Tuberculosis Dispensary should be provided and sent to certain recognized authorities in the borough for distribution.

(15) In connection with insured persons, the Tuberculosis Officers of the Tuberculosis Dispensaries should make special provision for the after-care of persons discharged from sanatoria and other institutions, and especially on the expiration of their twenty-six weeks' treatment, so that the beneficial results obtained therefrom may not be lost.

(16) A uniform system of issuing reports in connection with cases of Tuberculosis, to be sent out from the various institutions, should be prepared; also a uniform diagrammatic representation of the physical signs in the chest, which could be universally adopted.

(17) Central Bureau Example Case.

The case is examined by the panel doctor, and, if tuberculous, is notified to the Medical Officer of Health.

The patient wants Sanatorium Treatment; he is then examined by the Tuberculosis Officer and panel doctor.

Sanatorium Treatment is recommended; the Medical Record and

note as to the form of treatment to be received are then forwarded to the Medical Referee, who corroborates the opinion of the Tuberculosis Consulting Physician or Tuberculosis Officer *re* Sanatorium Treatment.

A letter is sent to the patient's home, informing him as to the decision, place of treatment, and time of departure of train.

The Medical Record is then forwarded to the sanatorium, and letters sent to the panel doctor and Tuberculosis Dispensary concerned, as to the decision.

If the case is not found suitable for Sanatorium Treatment, it is referred back to the Tuberculosis Dispensary concerned to be dealt with, and the Medical Record returned there.

NATIONAL ORGANIZATION.

Granting individual liberty of action on the part of local authorities in dealing with Tuberculosis in their areas, and the fact that the question is a national one, the one great necessity is co-ordination of effort, which can only be attained by its centralization. The difficulties of prosecuting any campaign against Tuberculosis are so great, and the authorities interested so numerous, that, unless a common line of action is pursued through a central organization, much effort and money will be wasted. What is required in each county and city is a Central Bureau for the organization of the work dealing with the whole tuberculous population, *i.e.*, insured and uninsured. For this to be dealt with by different authorities according to their own lines of action, is certain to end in chaos. Unfortunately, ample proof of this can already be furnished.

As the campaign against Tuberculosis is a national one, a Governmental Department ought to be established for organizing the work throughout the country. As few questions are so vital as the formation of a Ministry of Public Health in this country, a central department for dealing with Tuberculosis would come under its wing.

The question, however, is not only a national, but an international one, and by the establishment of such a Tuberculosis Department in the Ministry of Public Health, an interchange of views with such departments in other countries would be invaluable to all the authorities concerned. Let me add that no one who has studied the progress of events in relation to Public Health in this country can but regard the present as a ripe period for the formation of a Ministry of Public Health, and it is needless to say that such a matter lies outside party politics. The establishment of such a Ministry, with its Minister and permanent staff, is a necessity in the interests of Public Health, in order to unify

and consolidate Public Health work which is vested in the various Government Departments and other authorities. Under such a Ministry a department could be established for dealing with Tuberculosis.

Another great point in favour of the establishment of such a Ministry at this juncture would be its wise consideration of momentous questions which have arisen, and are bound to arise to a much greater extent, between the State, medical profession and the various voluntary institutions, such as hospitals, &c., in relation to Public Health. The administrators of such a department would be in an exceptional position to sift and co-ordinate the opinions of the various authorities concerned, and to enable them to settle those questions. Great issues which are looming in the distance in connection with the medical profession in its relation to State and municipality would be dealt with by such a department.

The important questions relating to the after-care and employment of tuberculous persons on leaving sanatoria, &c., and the education of tuberculous children, have all to be faced and solved in the immediate future, if the present organization for the detection and treatment of Tuberculosis by Tuberculosis Departments, hospitals, sanatoria, &c., is not largely to be nullified. To deal with such momentous issues requires the sifting and co-ordinating power of a Government Department, vested with the necessary authority which would be centred in a Ministry of Public Health. Nothing else will suffice.

CRITICISM OF THE LONDON COUNTY COUNCIL SCHEME.

Everyone interested in the question of dealing with Tuberculosis in London will welcome the adoption of the Council's Scheme. The Scheme, however, can in no sense be regarded as a comprehensive one, and it is sincerely hoped that it will undergo radical changes in the immediate future. The following comprise what may be regarded as its most favourable points :—

- (1) That it ensures co-operation with the great London Hospitals.
- (2) That it endeavours to make use of available institutions.
- (3) That the Tuberculosis Dispensary must be linked up with the Hospital, as one condition for giving grants.
- (4) That the patient, in order to have the advantage of Institutional Treatment under the Scheme, must undertake to remain under medical supervision on his discharge, *i.e.*, at a local Tuberculosis Dispensary or other suitable institution.

The following criticisms are advanced against the Scheme :—

(1) The class of persons to be dealt with.

Possibly the greatest error committed in drawing up this Scheme lies in the fact that only one class of persons, namely, uninsured, has been dealt with. No Scheme can be a satisfactory or comprehensive one without the inclusion of the whole tuberculous population. Such a comprehensive Scheme has been prepared and carried out in a satisfactory manner in other parts of the country, and the plea that the difficulties in dealing with Tuberculosis in London are so great, can scarcely be advanced as an excuse, as at the same time arrangements could equally well have been made for having insured persons dealt with under such a Scheme, and the funds apportioned for the treatment of such persons handed over to the London County Council by the London Insurance Committee.

(2) The Treatment or Segregation of Advanced and Chronic Cases.

In spite of the fact that it is universally granted that, apart from the treatment of tuberculous children, the treatment or segregation of advanced and chronic cases is the most pressing question, we find it stated in the Council's Scheme that "we have not taken into consideration any provision for advanced or chronic cases." It is stated that this should be dealt with by the Metropolitan Asylums Board, which wishes to provide Residential Treatment for uninsured persons by dealing directly with the local sanitary authorities, as it does in the case of persons suffering from infectious fevers. Here again we have further divided authority and controversy, and shifting of responsibility on to other authorities.

(3) Recommendation for Residential Treatment.

The arrangement for the selection of cases for Residential Treatment, *i.e.*, by reference from the medical practitioner or Tuberculosis Dispensary to the Local and County Medical Officers of Health, and thereafter to the Medical Referee, is a bad one, and bound to end in a failure to determine, at least clinically, the cases really suitable for Residential Treatment. By the Council's Scheme there is no obligation on the part of the Local Medical Officer of Health to refer for examination to the Tuberculosis Dispensary a case recommended for Residential Treatment by the medical practitioner before submitting it to the County Medical Officer of Health. If this is not done, untrustworthy clinical reports will, in numerous instances, be handed to the County Medical Officer of Health, and it will be quite impossible for the latter to sift the clinical evidence on which these recommendations are based. Accordingly, many cases thought to

be suitable will be recommended for Residential Treatment, without reference to the Medical Referees, and numerous cases will not be referred to them which on the surface seem to the Medical Officer of Health to be clinically trustworthy and devoid of any doubt. Under this Scheme the Medical Officer of Health is actually being put in the position of a clinical referee, to determine the suitability or unsuitability of cases, with or without reference to the Medical Referees. It must be granted that there will be comparatively little doubt as to the suitability or otherwise of cases from the Public Health point of view, and certainly the Medical Officer of Health is the authority for making such a decision.

Again, it might be asked, are the Local Medical Officers of Health to send to the County Medical Officers of Health *all* cases recommended to them by Tuberculosis Dispensaries and medical practitioners for Residential Treatment? If not, then again these officers are acting primarily as clinical referees. If they *are* to send up all cases, wherein lies the justification for supposing that the proposed cost of examination by the Medical Referees, in each case to be borne by the local sanitary authority of the district concerned, could prevent the possibility of a number of *unsuitable* cases being sent up for examination to the Referees? The other possibility must also have occurred to the Council, namely, that many *suitable* cases will *not* be sent up for such examination.

The solution of the whole problem is a simple one, and is detailed in my own Scheme (see Insured and Uninsured, Section A). While the Local and County Medical Officers of Health are the chief officers as far as Public Health is concerned, they should not be put in the position, as they have in the Council's Scheme, of dealing with the clinical aspects of tuberculous cases. All medical reports of tuberculous persons, who have been recommended for Residential Treatment, should be sent for final decision to the Medical Referees by the Tuberculosis Officer of the Tuberculosis Dispensary. The Tuberculosis Officer's recommendation should be based on a report which comprises the Public Health Report of the Home Conditions by the Local Medical Officer of Health concerned, and the clinical Medical Records of the case. The Medical Referee must be the judge as to whether he wishes to examine the patient or not.

By such an arrangement we have each case dealt with in a uniform manner, through uniform channels, from the medical practitioner to the Tuberculosis Officer, and onto the Medical Referee at the Central Bureau, for his decision. By such an arrangement for the recommendation of cases for Residential Treatment, the clinical factor must be paramount, but combined with it, is the Public Health Report.

(4) Criticism of the Advisory Medical Board.

The formation of such an Advisory Board can only be regarded as a matter of expediency, and it is sincerely hoped that as soon as possible it will be superseded by the establishment of a Central Bureau with its Medical Referees, such as I have provided for in my Scheme (see p. 4). This will lead to a much greater degree of efficiency in dealing with this work.

(5) Method of Selection of the Rota of Physicians or Medical Referees.

This rota of physicians, like the Advisory Medical Board, is also most unsatisfactory, and there is no doubt that such a formation, however good in itself, must only be regarded in each case as a temporary one of expediency, following on the desire to make the hospital the centre-piece of the Tuberculosis Scheme. Otherwise I feel sure that no such formation would have been contemplated. It is desirable that the work of the Medical Referees should be greatly reduced in course of time, and this is more likely to be brought about if every case of recommendation for Residential Treatment is sent directly to the Tuberculosis Dispensary before being referred to the Medical Referee. This is highly desirable both on clinical and economic grounds.

In relation to the examination by the Medical Referees of cases referred to them, the Council's Scheme provides that these Medical Referees shall attend at convenient centres for this purpose. Considering the limited number of patients who would have to be clinically examined by the Medical Referees in any well-organized Scheme, one centre, *i.e.*, the Central Bureau, should be provided for the examination of such cases, where the whole clinical and administrative work could be carried out.

(6) Children.

The arrangements mentioned for dealing with school children are unsatisfactory. Reference of cases of "special difficulty" by the School Medical Officer directly to the Medical Referee is highly unsatisfactory, and will incur unnecessary expense, if, as one would infer, the fee for that examination will be paid by the local authority concerned. One would have expected that such a case would have been referred by the School Medical Officer to the Tuberculosis Dispensary of the school district. The pressing and vital question as to the arrangements for providing suitable and adequate educational facilities in residential institutions for tuberculous children is passed over very lightly. Institutional and other treatment is just referred to, in direct contradistinction to the lines laid down in Germany for dealing

with tuberculous children. The Council's Scheme really only touches the very fringe of this question, which is possibly the most important factor in any campaign against Tuberculosis.

(7) Provision of Beds in Sanatoria and Hospitals.

With regard to Residential Treatment, the number of beds required in the different institutions has been greatly underestimated.

(8) The Reference of Cases to the various Departments of a Hospital.

As regards the reference of cases to departments of a Hospital, the Council's Scheme provides for such reference to be a direct one. This is fatal to a proper organization of the work in any district. Every such case should be referred through the Tuberculosis Officer of the Tuberculosis Dispensary, by which means only the Scheme can be properly worked. The same applies to the discharge of such patients.

(9) The provision that "local and sanitary authorities may make arrangements for patients residing in districts under their special jurisdiction, attending Dispensaries attached to Hospitals in any part of the administrative county," should not become a general rule, but only be made use of in cases of necessity, if any uniform system is to prevail.

(10) Admission of Tuberculous Persons into Hospitals for In-patient Treatment.

With reference to the admission of Tuberculous persons for In-patient Treatment into General and Special Institutions which accept payment for this purpose from the Council, certain objections have been raised to the fact that the Council reserves the right of sending into such institutions any cases it may choose. These objections have been raised on the plea that the physicians ought to have the power of refusing to admit such cases which they themselves may deem unsuitable. It seems to me that this plea is unreasonable, if they agree to the Council's Scheme for the selection of Medical Referees. If the authorities of these institutions place certain beds at the disposal of the Council, and accept payment for such, the Council surely has the right to send in any cases which it may choose, and which have been recommended for such treatment by its medical advisers, of whom the Hospital authorities themselves have approved. In any well-organized Scheme such an objection ought never to arise as far as the diagnosis and treatment of adults is concerned, but that it might in the case of children is quite a likely contingency.

(11) After-care of Patients.

It is desirable that, upon the discharge from a residential institution, any patient, adult or child, shall in every case be referred to the Tuberculosis Officer of the Tuberculosis Dispensary of the borough concerned, to be further dealt with, whatever other arrangements may be made in the case of children for their reference to the Children's Care Committees.

(12) The Obligations of the Medical Practitioner in relation to Recommendation for the Residential Treatment of the Uninsured.

The Council cannot expect that the medical practitioner has the time to, or will, investigate and report as to whether the patient cannot afford to pay for treatment, or can afford to pay to a specified extent, as the case may be.

ABBREVIATIONS USED IN THE CHARTS.

G.P.	General Practitioner.
P.D.	Panel Doctor.
T.O.	Tuberculosis Officer.
T.D.	Tuberculosis Dispensary.
T.N.	Tuberculosis Nurse.
M.R.	Medical Referee.
C.B.	Central Bureau.
M.O.H.	Medical Officer of Health.
O.P.	Out-Patient.
L.I.C.	London Insurance Committee.
T.C.P.	Tuberculosis Consulting Physician
R.M.O.	Resident Medical Officer.
M.A.B.	Metropolitan Asylums Board.
B.G.	Board of Guardians.
G.D.	General Dispensary

CHART I INSURED

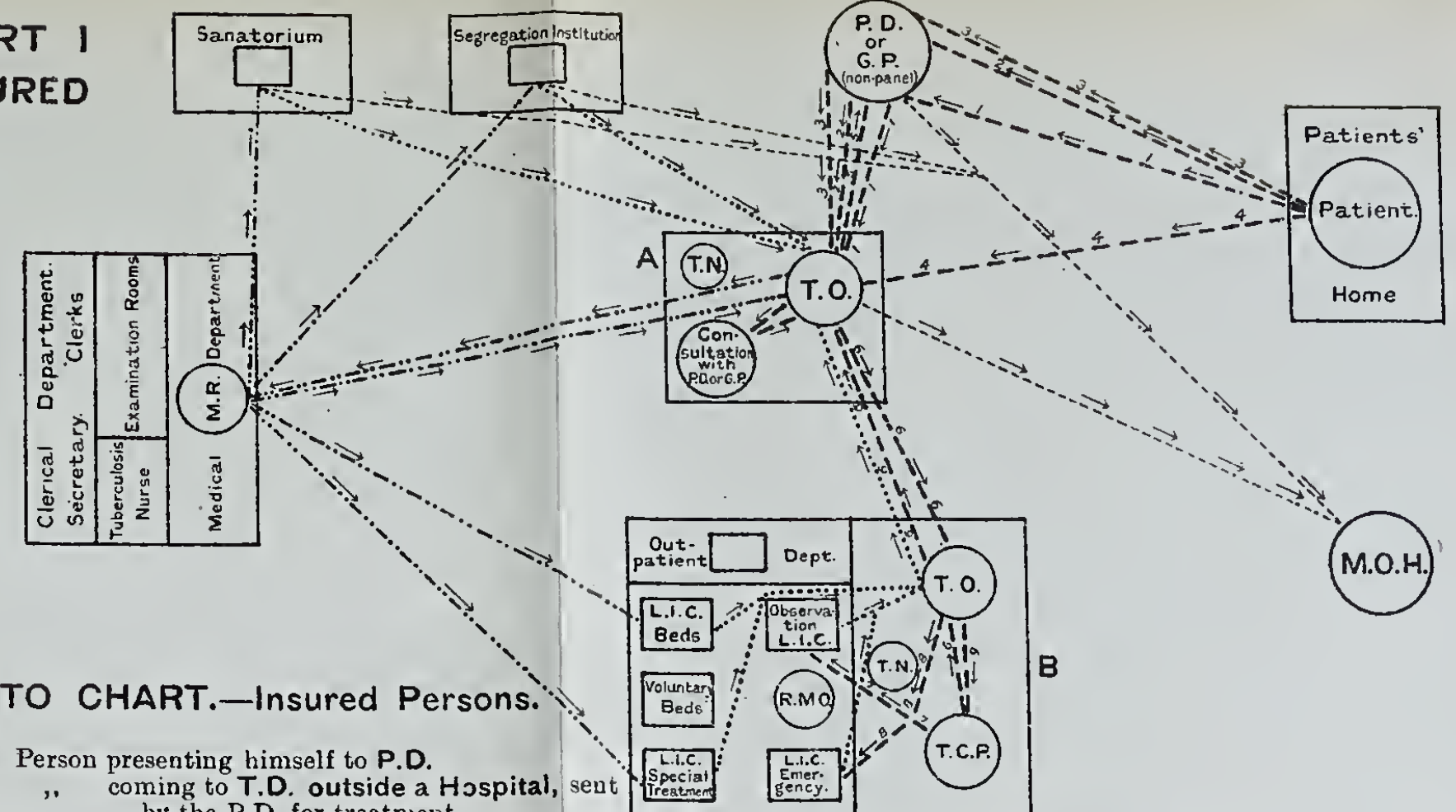
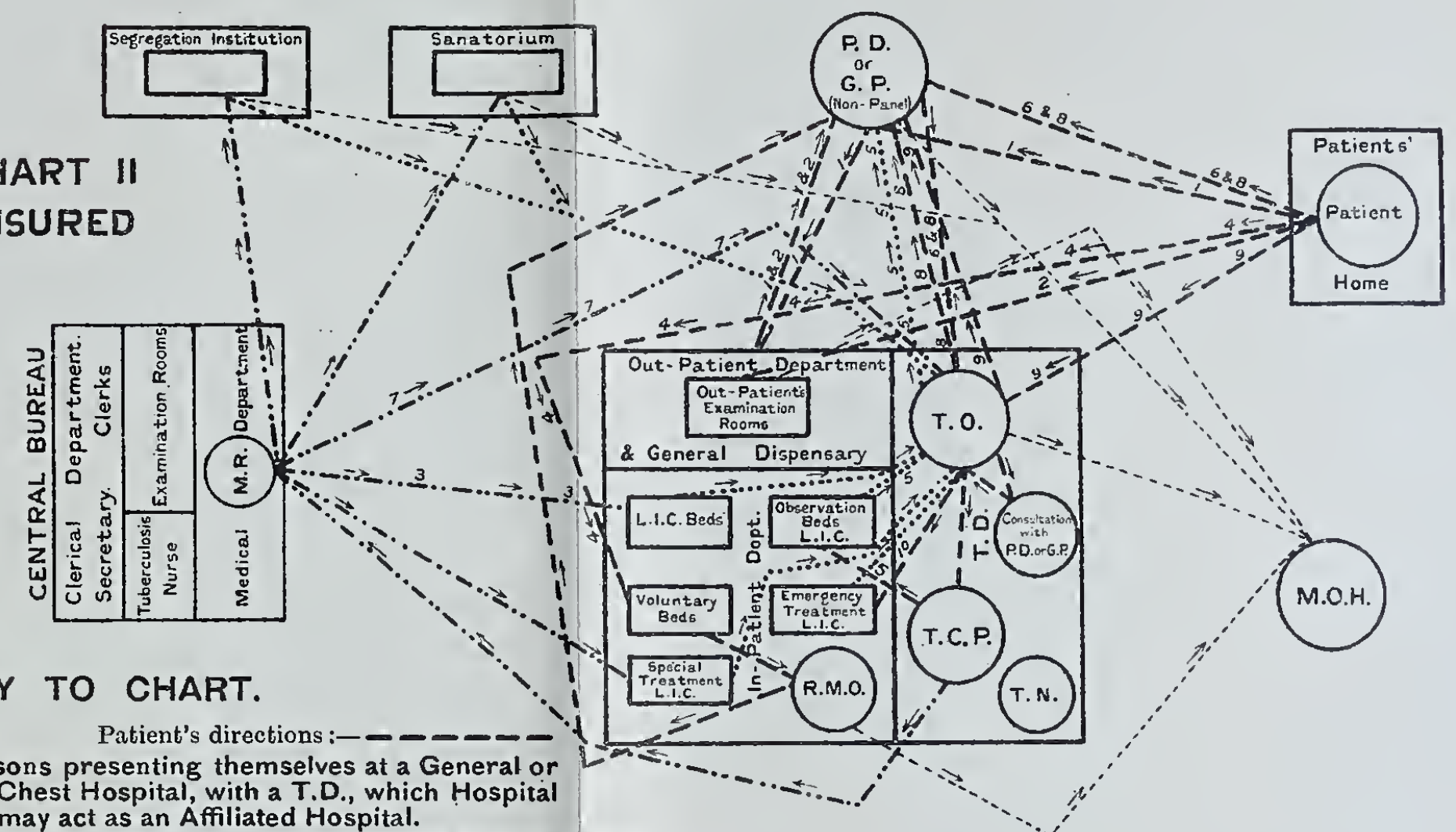


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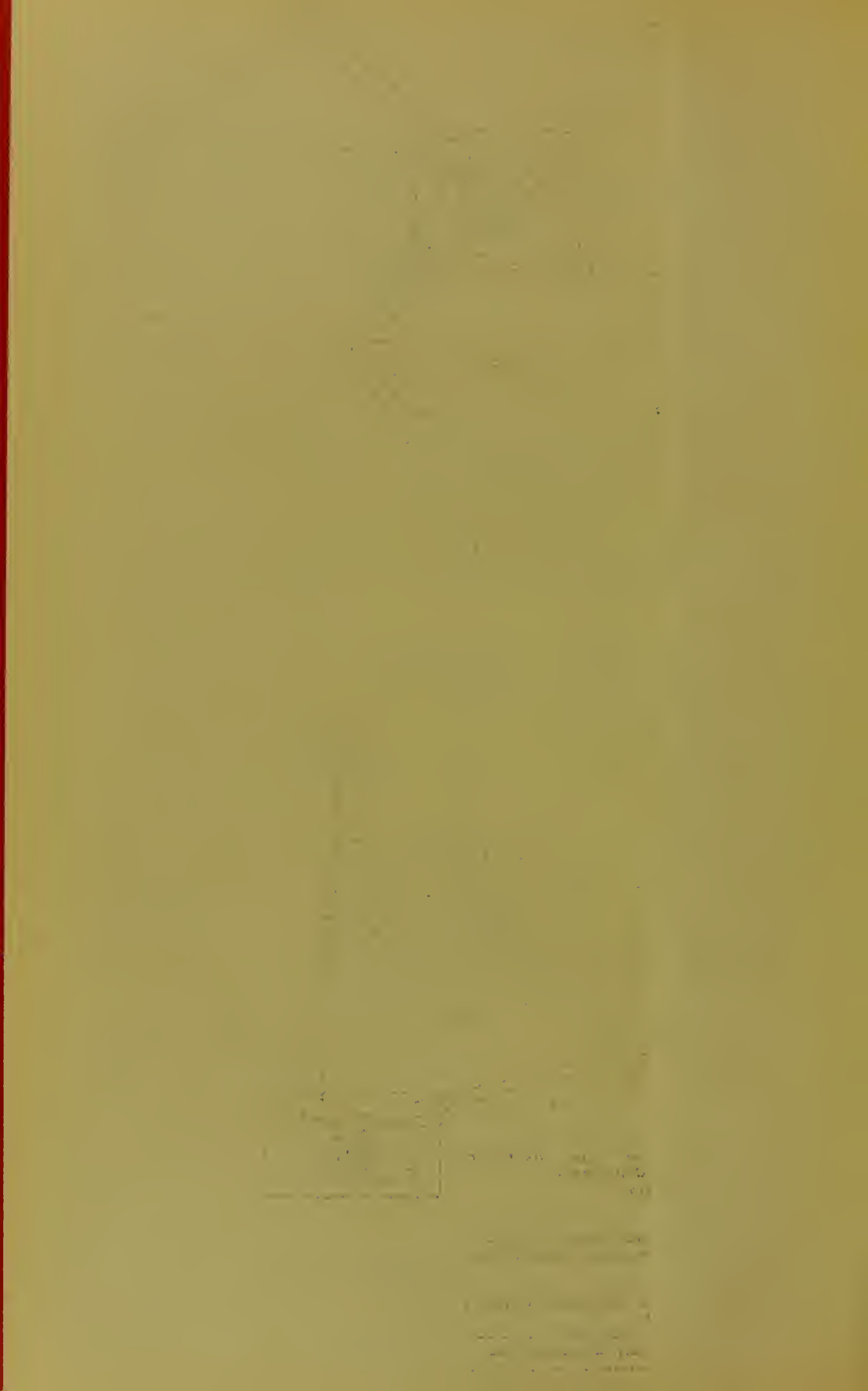
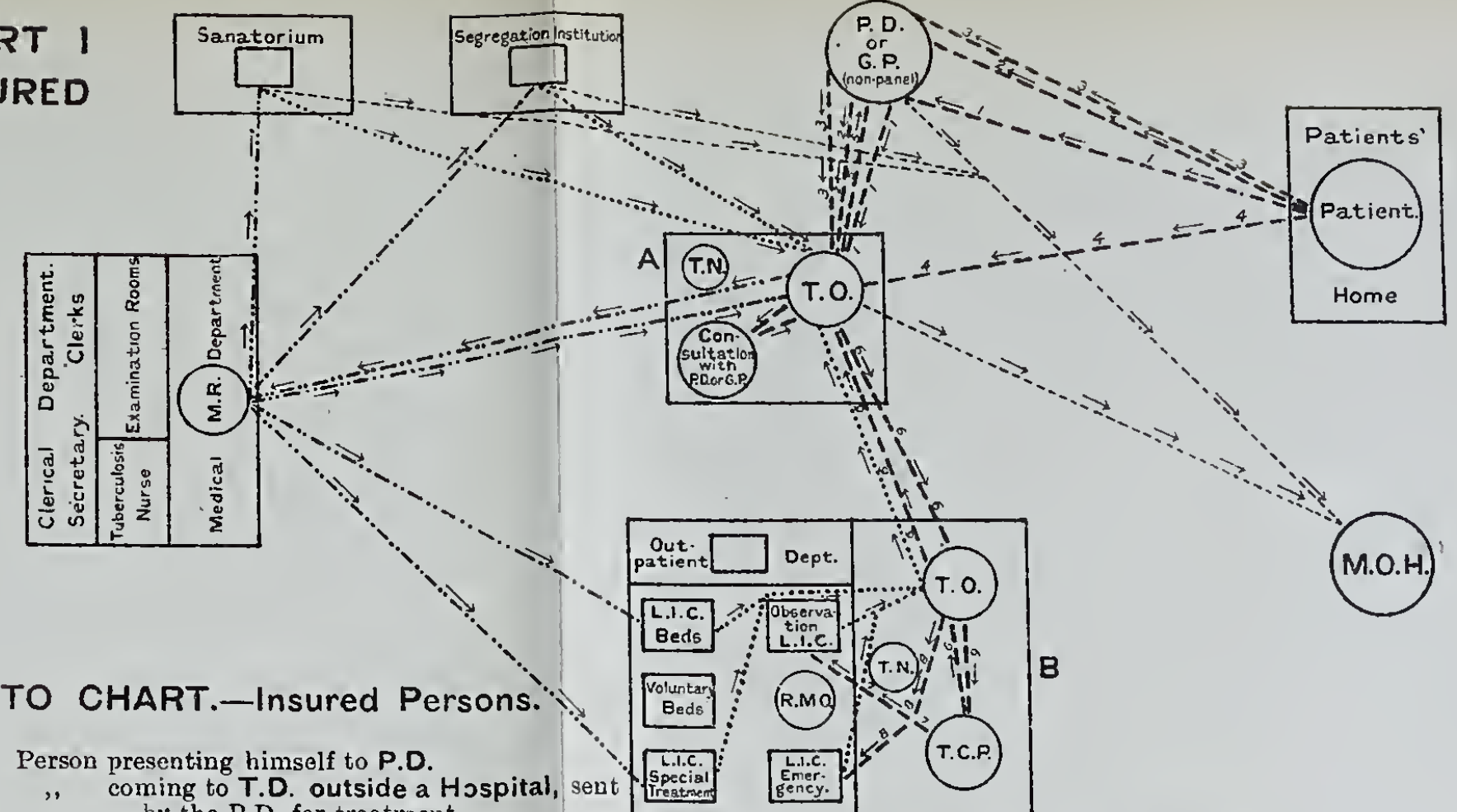


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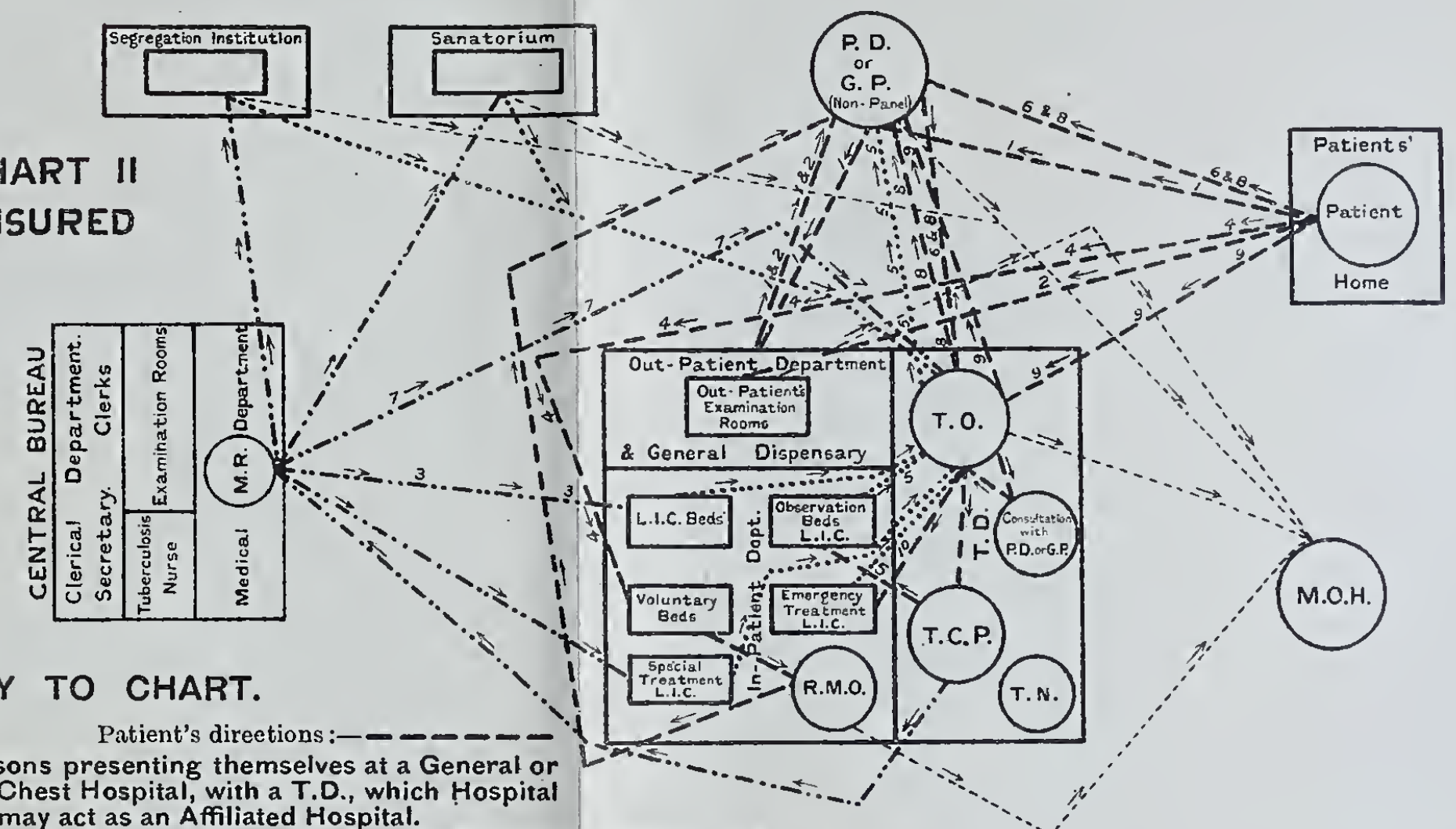


KEY TO CHART.—Insured Persons.

- Line 1. Person presenting himself to P.D.
 „ 2. „ coming to T.D. outside a Hospital, sent by the P.D. for treatment.
 „ 3. „ sent by the P.D. for diagnosis.
 „ 4. „ coming independently.
 „ 5. Reference back to P.D. if Domic. Treatment by the P.D. recommended.
 „ 6. „ to T.D. of Affiliated Hospital, for diagnosis.
 „ 7. „ from T.C.P. to Observation Wards.
 „ 8. „ from T.O. to Emergency Beds.

Line of recommendation for Inst. Treatment:—
 „ „ notification to M.O.H.:—
 „ „ discharge after Inst. Treatment:—
 (A) = T.D. outside Hospital, affiliated to B, Hospital with a T.D.

CHART II INSURED



KEY TO CHART.

Patient's directions:—

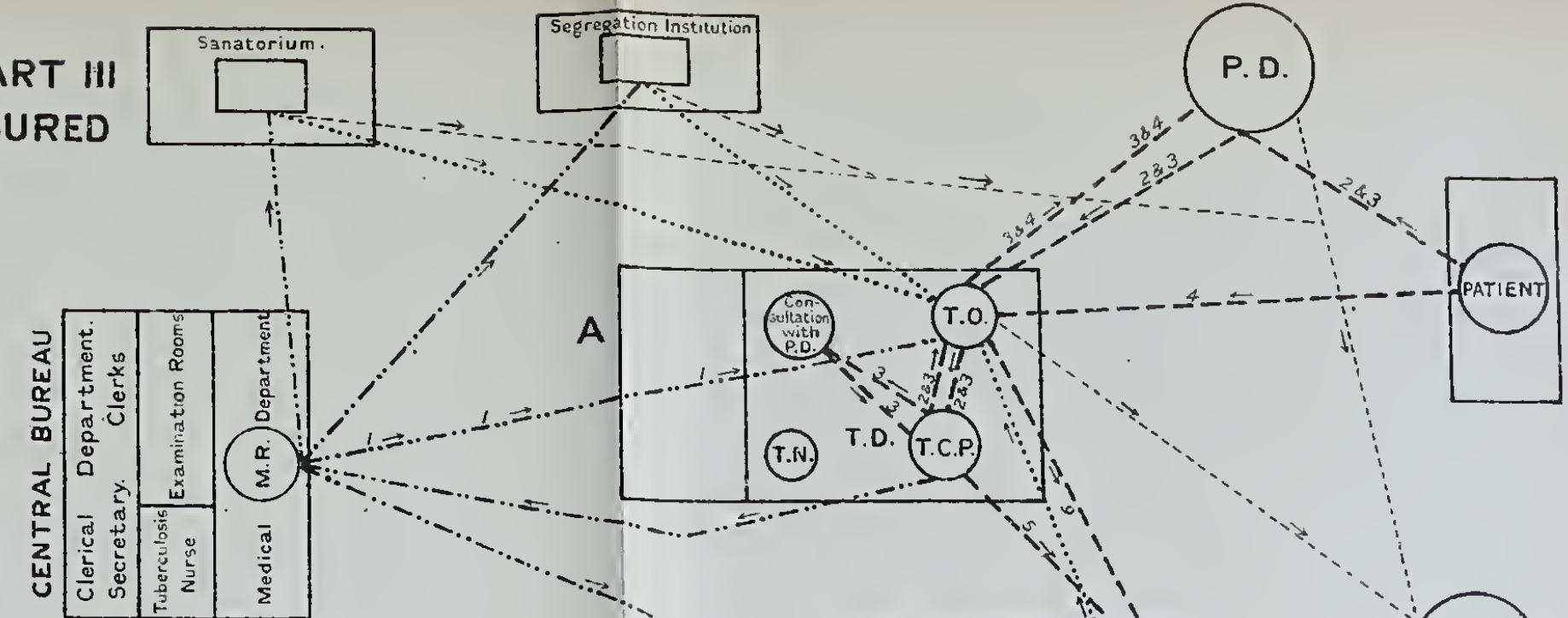
Persons presenting themselves at a General or Chest Hospital, with a T.D., which Hospital may act as an Affiliated Hospital.

- (1) Out-Patient Dept.—Cases referred for diagnosis by the P.D. or G.P.:—
 (2) „ „ coming with Hospital letter.
 (3) In-Patient Dept.—Beds for treatment (L.I.C.).
 (4) „ „ Voluntary Beds. Cases coming independently.
 (5) „ „ Observation Beds (L.I.C.).
 (6) T.D.—Special and Emergency Cases sent by the P.D. for treatment.
 (7) „ Cases referred from the C.B. for T.D. Treatment.
 (8) „ sent by P.D. or G.P. for diagnosis.
 (9) „ coming with or without T.D. Admission Card, or from Vol. Agencies.

Line of recommendation for Institutional Treatment:—
 „ „ discharge after Institutional Treatment:—
 „ „ notification to the M.O.H.:—
 (10) Case sent by T.O. to Emergency Beds for treatment.

Unnumbered lines are applicable for all cases, i.e., Consultation with P.D. or G.P., if necessary, and reference to T.C.P. for recommendation for Institutional Treatment and for all cases sent up by P.D. or G.P., or from the Affil. T.D. See Chart I.

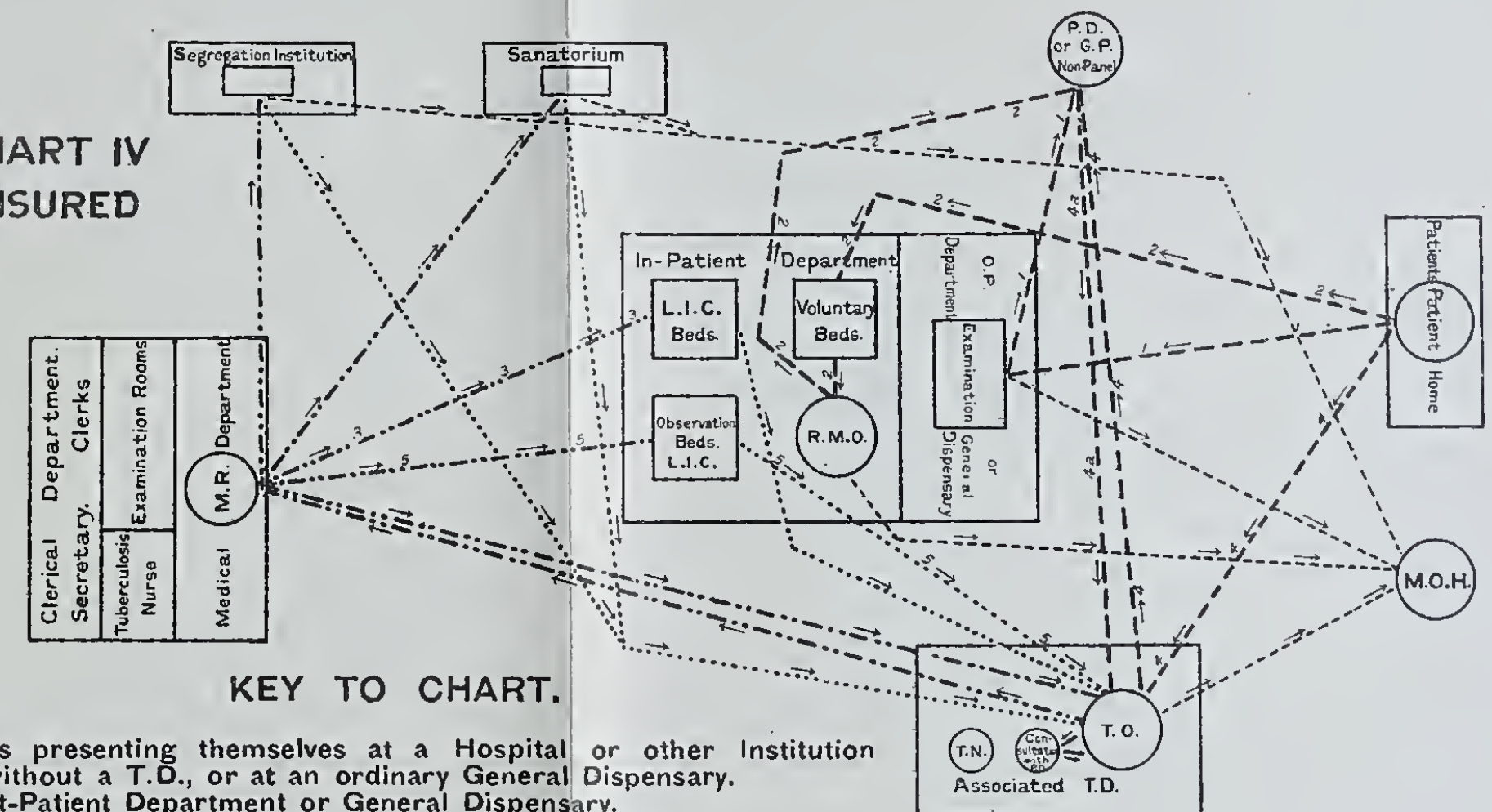
CHART III INSURED



KEY TO CHART.

- (A) General Dispensary with T.D., affiliated to
- (B) General or Chest Hospital, with T.D.
- Patient presenting himself at T.D. inside Gen. Dispensary.
- (1) Sent from the L.I.C., through the C.B. for T.D. Treatment.
- (2) " " " P.D. for treatment.
- (3) " " " P.D. for diagnosis, referred back to P.D. with medical report.
- (4) Coming independently by T.D. Admission Card.
- (5) Reference to T.D. of Affiliated Hospital for treatment in Observation Beds, if desired.
- (6) Reference by T.O. to Emergency Beds of Affiliated Hospital.
- Notification to the M.O.H. :-----
- M.R.'s Recommendation for Institutional or T.D. Treatment :-----
- Discharge after Institutional Treatment :-----

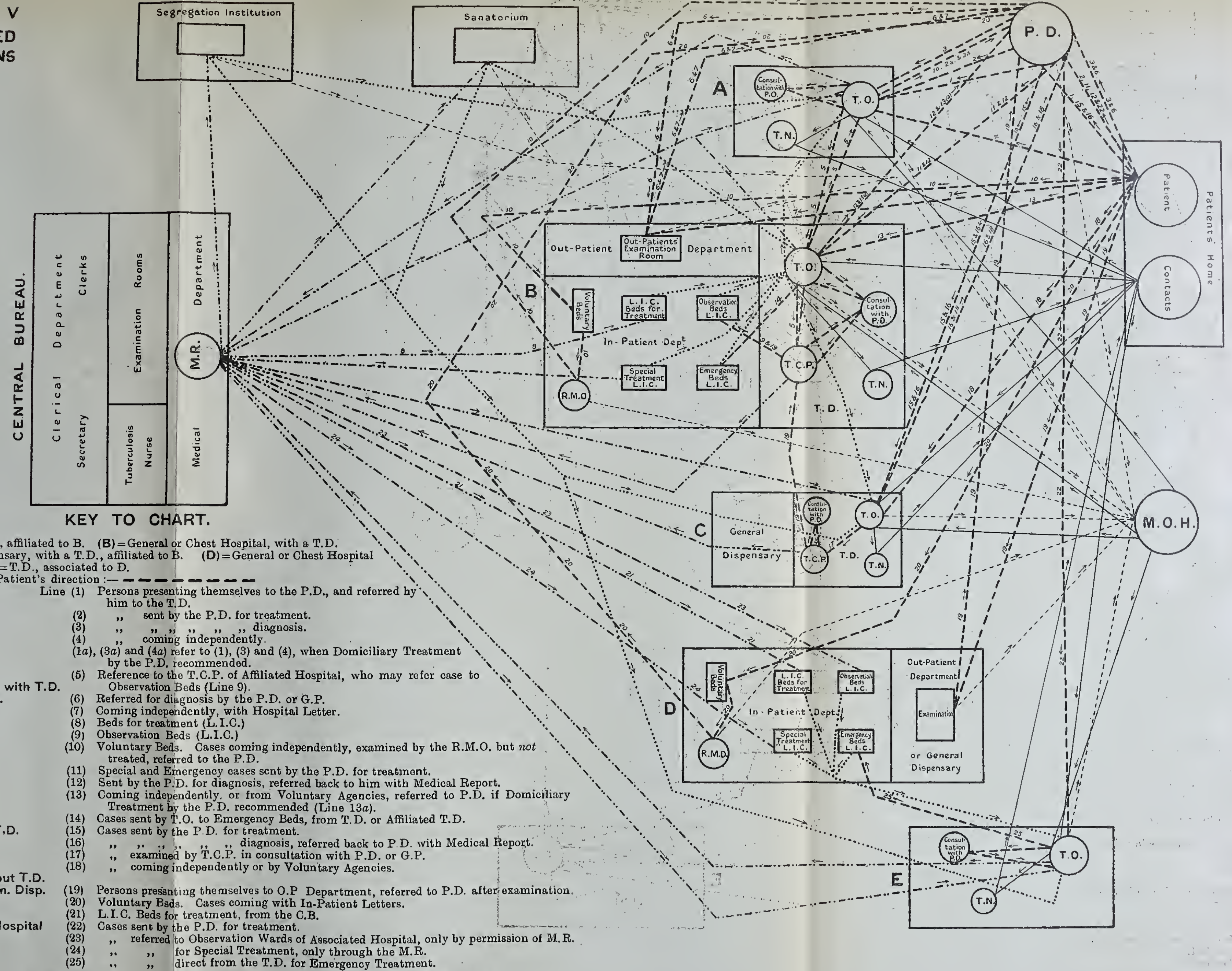
CHART IV INSURED



KEY TO CHART.

- Persons presenting themselves at a Hospital or other Institution without a T.D., or at an ordinary General Dispensary.
- (1) Out-Patient Department or General Dispensary.
 - (2) In-Patient Department :—Voluntary Beds.
Cases coming with In-Patient Letters.
 - (3) L.I.C. Beds :—Cases sent in for treatment (through the C.B.).
 - (4) T.D. Associated to above Hospital :—Cases presenting themselves by Admission Letter or otherwise.
 - (4a) Cases referred back by the P.D. for treatment.
 - (5) Cases referred by the T.O. of Associated T.D. to Observation Wards of Hospital, only by arrangement with the M.R.
 - Line of notification to the M.O.H. :-----
 - " " recommendation for Institutional Treatment :-----
 - " " discharge after Institutional Treatment :-----

CHART V INSURED PERSONS



KEY TO CHART.

- (A)=T.D. outside a Hospital, affiliated to B. (B)=General or Chest Hospital, with a T.D. (C)=General Dispensary, with a T.D., affiliated to B. (D)=General or Chest Hospital without a T.D. E=T.D., associated to D.
- Patient's direction: —————
- P.D. Line (1) Persons presenting themselves to the P.D., and referred by him to the T.D.
- T.D. outside Hospital. (2) " sent by the P.D. for treatment. (3) " " " " " diagnosis. (4) " coming independently. (1a), (3a) and (4a) refer to (1), (3) and (4), when Domiciliary Treatment by the P.D. recommended.
- General or Chest Hospital with T.D. (5) Reference to the T.C.P. of Affiliated Hospital, who may refer case to Observation Beds (Line 9). (6) Referred for diagnosis by the P.D. or G.P. (7) Coming independently, with Hospital Letter. (8) Beds for treatment (L.I.C.) (9) Observation Beds (L.I.C.)
- In-Patient " (10) Voluntary Beds. Cases coming independently, examined by the R.M.O. but not treated, referred to the P.D.
- T.D. (11) Special and Emergency cases sent by the P.D. for treatment. (12) Sent by the P.D. for diagnosis, referred back to him with Medical Report. (13) Coming independently, or from Voluntary Agencies, referred to P.D. if Domiciliary Treatment by the P.D. recommended (Line 13a).
- General Dispensary with T.D. (14) Cases sent by T.O. to Emergency Beds, from T.D. or Affiliated T.D. (15) Cases sent by the P.D. for treatment. (16) " " " " " diagnosis, referred back to P.D. with Medical Report. (17) " examined by T.C.P. in consultation with P.D. or G.P. (18) " coming independently or by Voluntary Agencies.
- Gen. or Chest Hosp. without T.D. (19) Persons presenting themselves to O.P. Department, referred to P.D. after examination. (20) Voluntary Beds. Cases coming with In-Patient Letters. (21) L.I.C. Beds for treatment, from the C.B. (22) Cases sent by the P.D. for treatment. (23) " referred to Observation Wards of Associated Hospital, only by permission of M.R. (24) " " for Special Treatment, only through the M.R. (25) " " direct from the T.D. for Emergency Treatment.

Notification to the M.O.H. of case of Tuberculosis: ————— Examination of contacts: —————

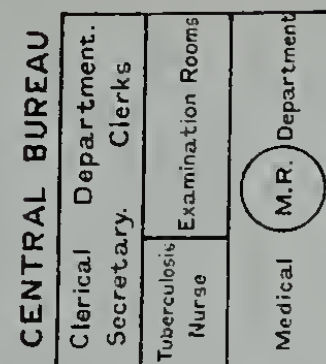
Recommendation to the M.R. for Institutional Treatment —Sanatorium, Segregation, Hospital (L.I.C. Beds), (Ordinary or Special), or back again to the T.D. for T.D. Treatment: —————

Discharge after Institutional Treatment, referred back again to respective T.D.: —————

Discharge from Observation Beds, referred back to respective T.D.: —————

In the case of reference from Affiliated T.D. to Observation Wards of Hospital with a T.D., the case, on discharge, is referred back to Affiliated T.D. through the Hospital T.D.

CHART VI UNINSURED



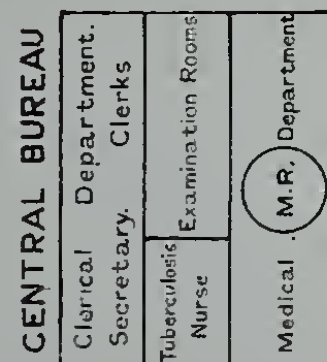
KEY TO CHART.

Patient's directions: ————

- (1) Persons presenting themselves to the G.P., incl. the Poor Law Medical Officer.
- (1a) If G.P. wishes for consultation at T.D. or if patient unable to pay, case referred to the T.D.
- Persons presenting themselves at a T.D. outside a Hospital.
- (2) Cases sent by the M.O.H. for diagnosis and treatment.
- (3) " " " " G.P. (incl. Poor Law Medical Officer).
- (4) " " coming independently or by Voluntary Agencies.
- (5) Persons able to pay, referred to G.P. if Domiciliary Treatment recommended.
- (6) Reference to T.C.P. of Affiliated Hospital, if T.O. so wishes.
- (7) " " Observation Beds, if desired.
- (8) Emergency cases from Affiliated T.D.

Recommendation for Inst. Treatment: ————
 Discharge after Inst. Treatment: ————
 Notification to M.O.H.: ————
 (A) = T.D. outside a Hospital, affiliated to
 (B) = Hospital (Gen. or Chest) with a T.D.

CHART VII UNINSURED



KEY TO CHART.

Persons presenting themselves at a General or Chest Hospital (which may act as an Affiliated Hospital Centre) or at a General Dispensary, with a T.D.

Direction of Patients: ————

Out-Patient Dept., and General Dispensary.

- (1) Cases sent up by G.P.
- (2) " " coming up by Hospital O.P. Admission Letter.
- (1a) and (2a) Cases able to pay, referred to G.P.
- (1b) and (2b) Cases unable to pay, referred to T.D.

The patient, however, if unable to pay, may attend the O.P. Dept. if he so desires.

In-Patient Dept.

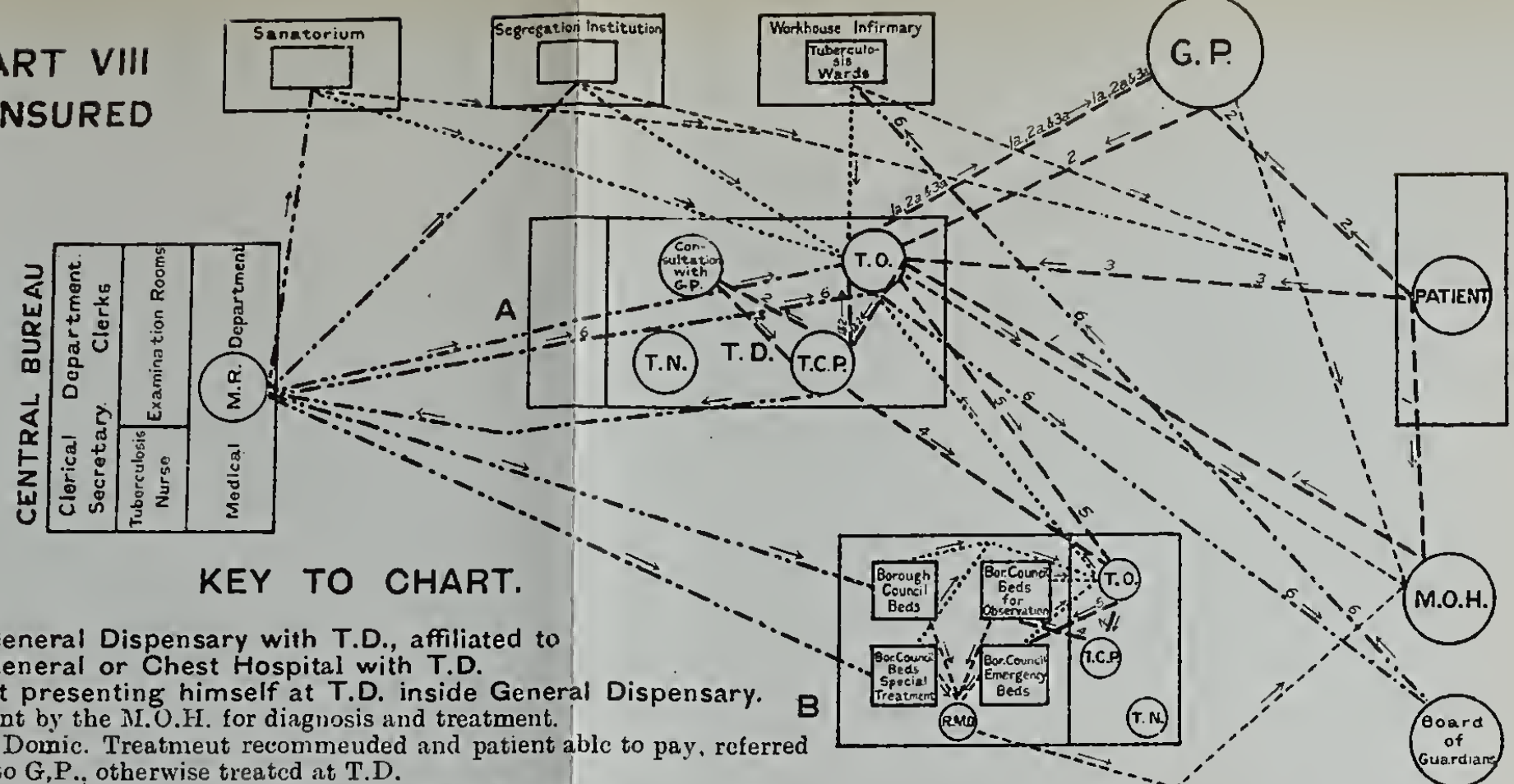
- (3) Cases sent in to Borough Council Beds from the T.D. and through the C.B.
- (4) Cases coming to Voluntary Beds with Hospital Admission Letter.
- (5) " " sent to Observation Beds. If diagnosed as tuberculous and able to pay, referred to G.P., if unable to pay, treated at T.D.

T.D., or Dept. for the Prevention of Consumption.

- (6) Cases sent by the M.O.H. for diagnosis and treatment.
- (7) " " " " G.P., incl. the Poor Law Med. Officer.
- (8) " " coming independently or by Voluntary Agencies.
- (9) " " referred by T.O. to T.C.P., compulsory for cases rec. for Inst. Treatment and also for all cases sent from Affil. T.D. or by the G.P.

6a, 7a, and 8a refer to cases 6, 7, 8, if able to pay, referred to G.P. if Domiciliary Treatment recommended. If unable to pay they are treated at the T.D.
 (10) Cases sent in for Emergency Treatment.
 Lines of recommendation for Inst. Treatment: ————
 " " discharge after Inst. Treatment: ————
 " " notification to the M.O.H.: ————

CHART VIII UNINSURED

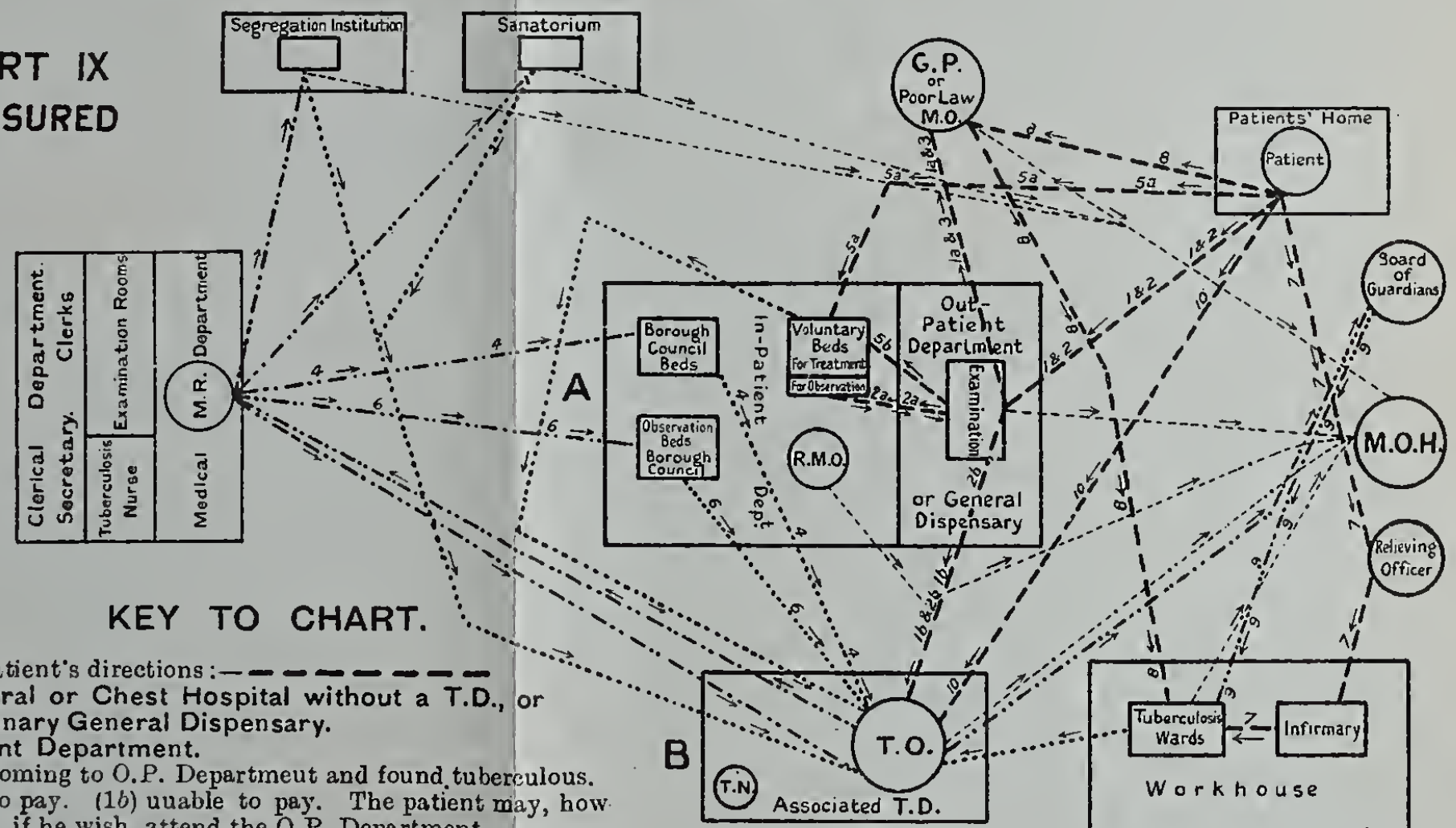


KEY TO CHART.

- (A) General Dispensary with T.D., affiliated to
(B) General or Chest Hospital with T.D.
Patient presenting himself at T.D. inside General Dispensary.
- (1) Sent by the M.O.H. for diagnosis and treatment.
 - (1a) If Domic. Treatment recommended and patient able to pay, referred to G.P., otherwise treated at T.D.
 - (2) Sent by the G.P., including the Poor Law M.O.
 - (2a) If Domic. Treatment recommended and patient able to pay, referred to G.P., otherwise treated at the T.D.
 - (3) Patient coming independently.
 - (3a) If recommended Domiciliary Treatment and able to pay, case is referred to G.P., otherwise it is treated at the T.D.
 - (4) Reference to T.D. of Affiliated Hospital for Observation Beds.
 - (5) Reference by T.O. to Emergency Beds, through T.O. of Affil. Hospital.

- (6) Recommendation by M.R. for Segregation in Workhouse Infirmary, by arrangement with Board of Guardians.
- Recommendation by the M.R. for Institutional or T.D. Treatment: —————
- Discharge after Inst. or T.D. Treatment: —————
- Notification to the M.O.H.: —————

CHART IX UNINSURED



KEY TO CHART.

- Patient's directions: —————
- (A) General or Chest Hospital without a T.D., or ordinary General Dispensary.
Out-Patient Department.
- (1) Case coming to O.P. Department and found tuberculous.
 - (1a) Able to pay. (1b) unable to pay. The patient may, however, if he wish, attend the O.P. Department.
 - (2) Case examined and diagnosis doubtful.
 - (2a) „ sent for observation to Voluntary Beds, or
 - (2b) „ referred to T.D. to be dealt with.
 - (3) „ after observation found tuberculous and able to pay, referred to G.P.
- In-Patient Department.
Borough Council Beds.
- (4) Cases admitted from Associated T.D. (B), through the C.B. Voluntary Beds.
 - (5a) Cases presenting themselves with Hospital Letter, or
 - (5b) from the O.P. Department.
 - (6) Cases admitted to Observation Beds from Associated T.D. through the C.B.
- N.B.—Case 5a only admitted to Vol. Beds if bed available and case suitable for treatment, otherwise referred to T.D.

Workhouse Infirmary Hospital.

- (7) Cases sent in by the Relieving Officer and found tuberculous.
 - (8) Cases sent in as tuberculous by the Poor Law M.O.
 - (B) Associated to (A)
 - (9) Cases received for Inst. Treatment at the Workhouse Infirmary, by decision of the Board of Guardians.
 - (10) Cases presenting themselves at Associated T.D., unable to pay.
- Recommendation for Inst. Treatment: —————
- Discharge after Inst. Treatment: —————
- Notification to the M.O.H.: —————

PROPERTY DESCRIPTION
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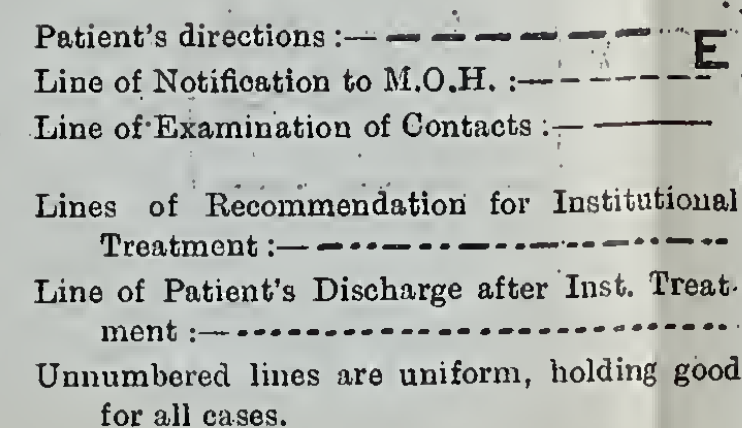




TABLE 1

UNIT 1

1	2	3	4
5	6	7	8
9	10	11	12
13	14	15	16



TABLE 2

UNIT 1

1	2	3	4
5	6	7	8
9	10	11	12
13	14	15	16



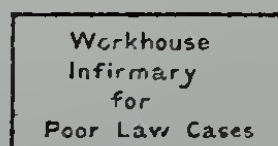
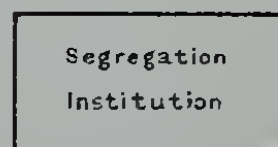
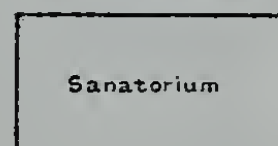
CHART XI

CHART FOR CONTACTS (Insured and Uninsured).

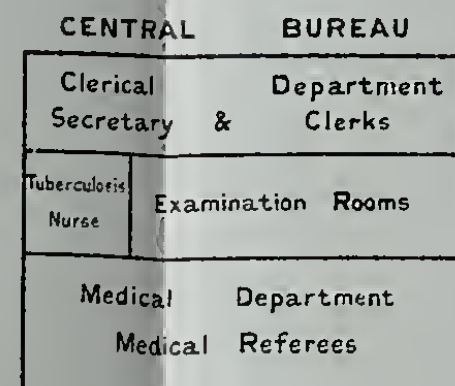
Line of notification to M.O.H. :-----
 " " examination of contacts :-----
 " " contacts themselves :-----
 (A)=Insured contacts. (B)=Uninsured contacts.
 Insured, if found tuberculous, referred to the P.D.
 Uninsured, " " " " " " " " G.P. if able
 " " " " " " " " to pay.
 " " " " " " " " and if unable to pay, treated
 " " " " " " " " at the T.D.
 For after procedure of Insured and Uninsured see Section A in
 Scheme (Insured and Uninsured).
 N.B.—If the contacts are unable to come to the T.D., the
 T.O. will examine them at the homes, see dotted
 line:-----

CHART XII

INSTITUTIONAL TREATMENT (Inside or Outside Borough)



BOROUGH with (A) General or Chest Hospital with T.D.



M.O.H.

A

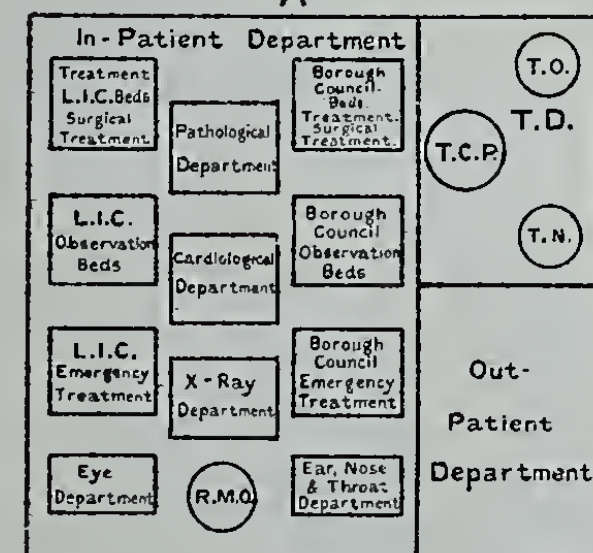


CHART XIII

INSTITUTIONAL
TREATMENT
(Inside or Outside Borough)

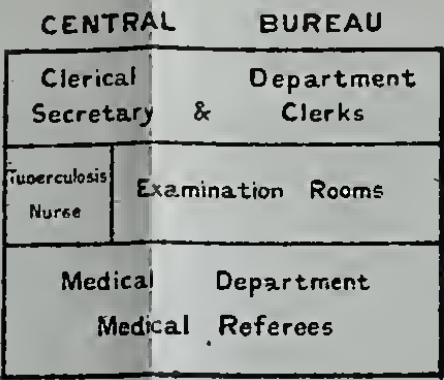
Sanatorium

Segregation
Institution

Workhouse
Infirmary
for
Poor Law Cases

BOROUGH

- with
(A) General or Chest Hospital, without T.D.
and
(B) Associated Tuberculosis Dispensary.



M.O.H.

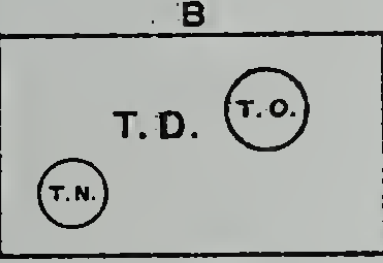
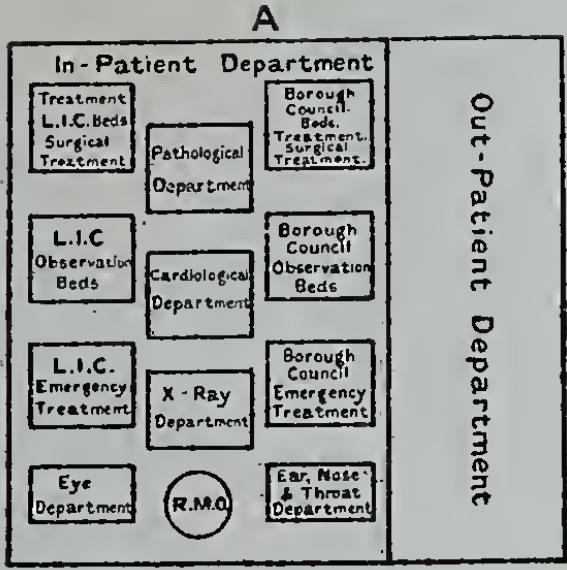


CHART XIV

INSTITUTIONAL
TREATMENT
(Inside or Outside Borough)

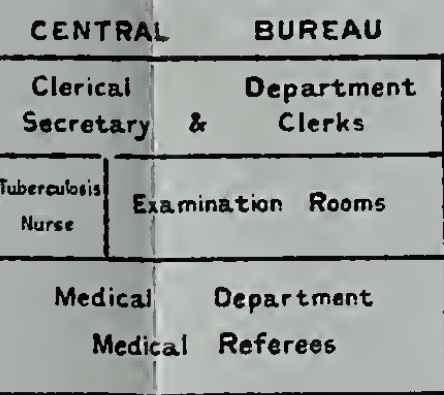
Sanatorium

Segregation
Institution

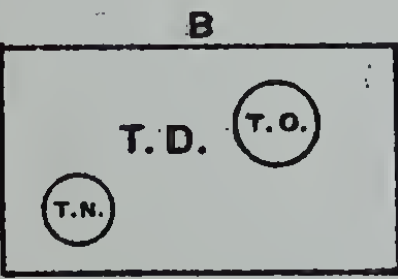
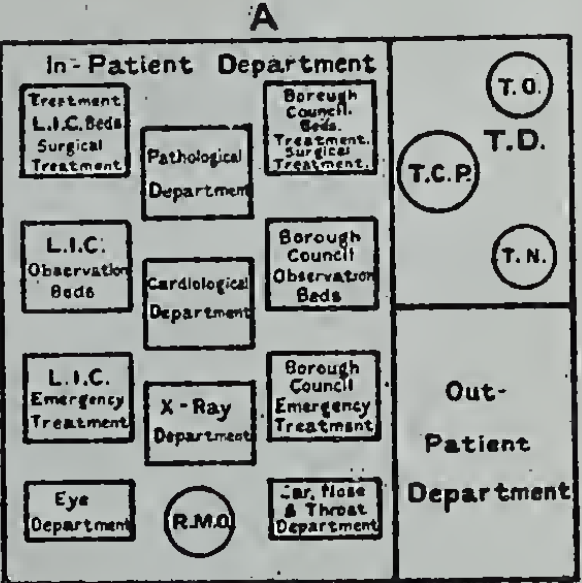
Workhouse
Infirmary
for
Poor Law Cases

BOROUGH

- with
(A) General or Chest Hospital with T.D.
and
(B) Affiliated Municipal T. Dispensary



M.O.H.



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